

# The Journal

of the Michigan State Medical Society

July, 1956

Volume 55

Number 7



91<sup>st</sup>  
Annual  
Session

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# THE JOURNAL of the Michigan State Medical Society

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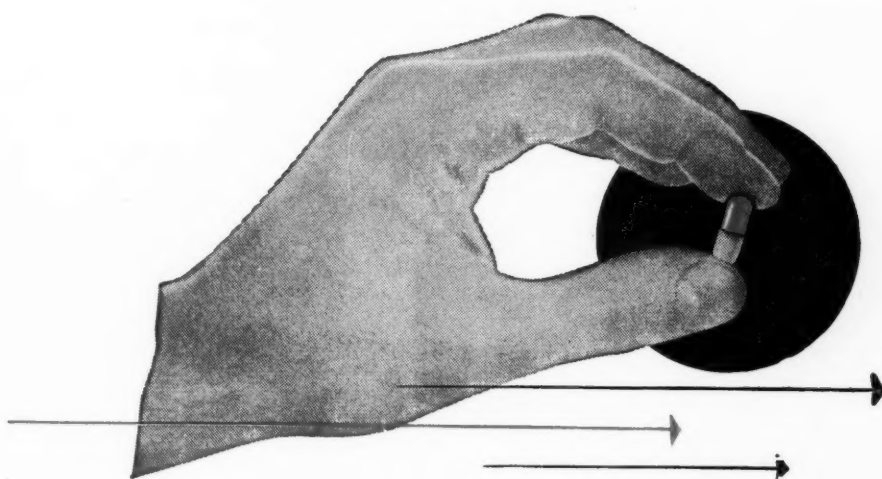
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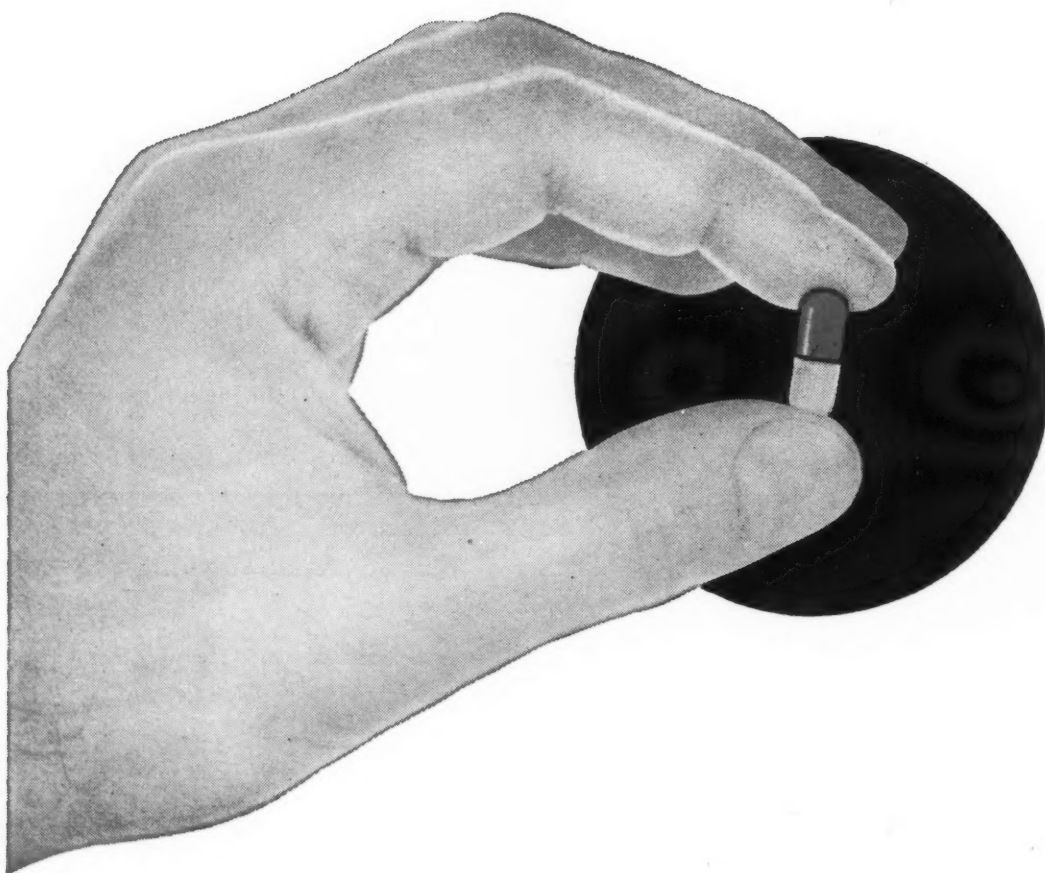
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| NEWAYGO                        | Tunis VandenBerg, M.D., Fremont        | J. P. Klein, M.D., 16 W. Sheridan Street, Fremont            |
| NORTH CENTRAL                  | M. A. Martzowka, M.D., Roscommon       | R. G. Barstow, M.D., Gaylord                                 |
| NORTHERN MICHIGAN              | B. T. Alm, M.D., Petoskey              | E. F. Crippen, M.D., 126½ State Street, Mancelona            |
| OAKLAND                        | A. R. Young, M.D., Pontiac             | G. N. Petroff, M.D., 1301 Pontiac State Bank Bldg., Pontiac  |
| OCEANA                         | W. G. Robinson, M.D., Hart             | W. G. Robinson, M.D., 219 State Street, Hart                 |
| ONTONAGON                      | H. B. Hogue, M.D., Ewen                | W. F. Strong, M.D., Ontonagon                                |
| OTTAWA                         | F. W. DeYoung, M.D., Spring Lake       | V. L. Boersma, M.D., 97 E. 30th Street, Holland              |
| SAGINAW                        | A. K. Cameron, M.D., Saginaw           | R. V. Bucklin, M.D., 1447 N. Harrison Street, Saginaw        |
| ST. CLAIR                      | Walter S. Novak, M.D., Port Huron      | C. D. Selby, M.D., 1916 Military, Port Huron                 |
| ST. JOSEPH                     | J. M. Jacobowitz, M.D., Three Rivers   | C. G. Porter, M.D., 226 East Street, Three Rivers            |
| SANILAC                        | R. J. Winfield, M.D., Marlette         | E. W. Blanchard, M.D., Deckerville                           |
| SHIAWASSEE                     | J. E. Harroun, M.D., Owosso            | E. S. Austin, M.D., 113 E. Williams Street, Owosso           |
| TUSCOLA                        | E. J. Miles, M.D., Caro                | E. N. Elmendorf, M.D., Vassar                                |
| VAN BUREN                      | M. W. Buckborough, M.D., South Haven   | D. K. Morgan, M.D., South Haven                              |
| WASHTENAW                      | L. Dell Henry, M.D., Ann Arbor         | B. C. Payne, M.D., 202 Michigan Theatre Bldg., Ann Arbor     |
| WAYNE                          | L. R. Leader, M.D., Detroit            | R. R. Cooper, M.D., 4421 Woodward Avenue, Detroit            |
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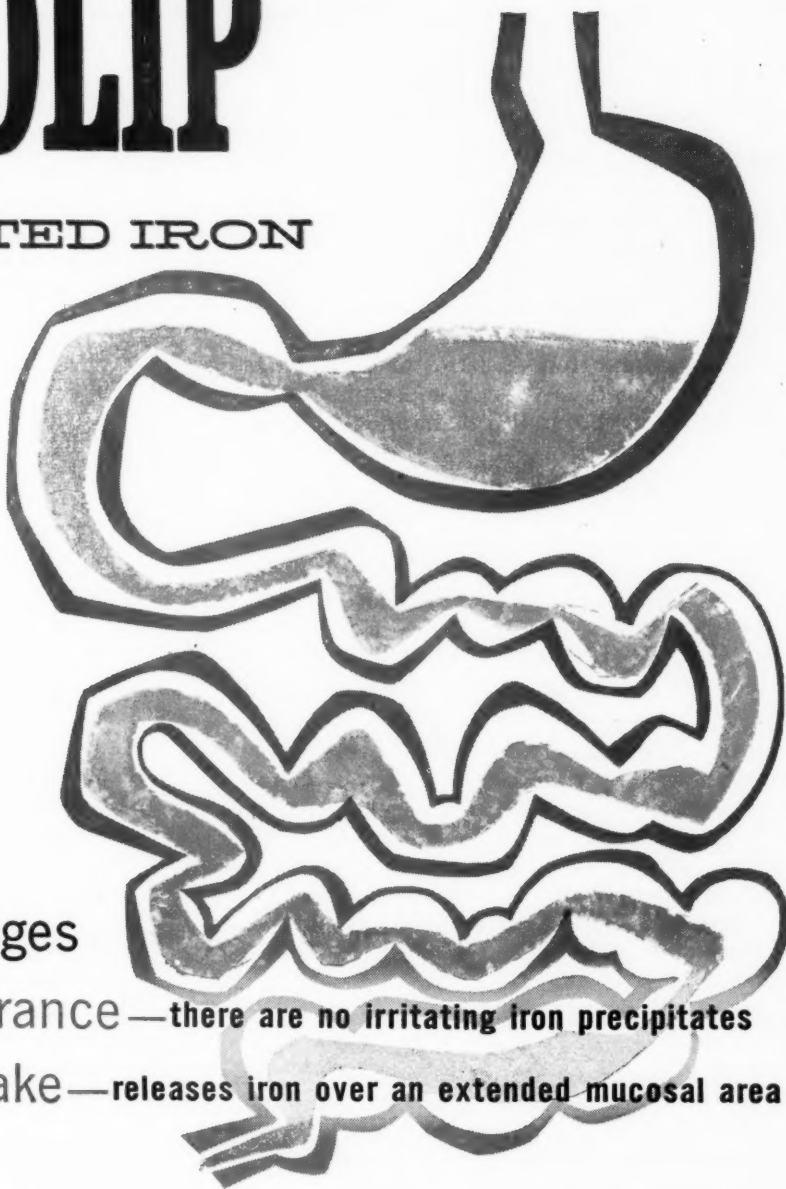
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JULY, 1956

Say you saw it in the Journal of the Michigan State Medical Society

765

# You and Your Business

## HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of May 16, 1956

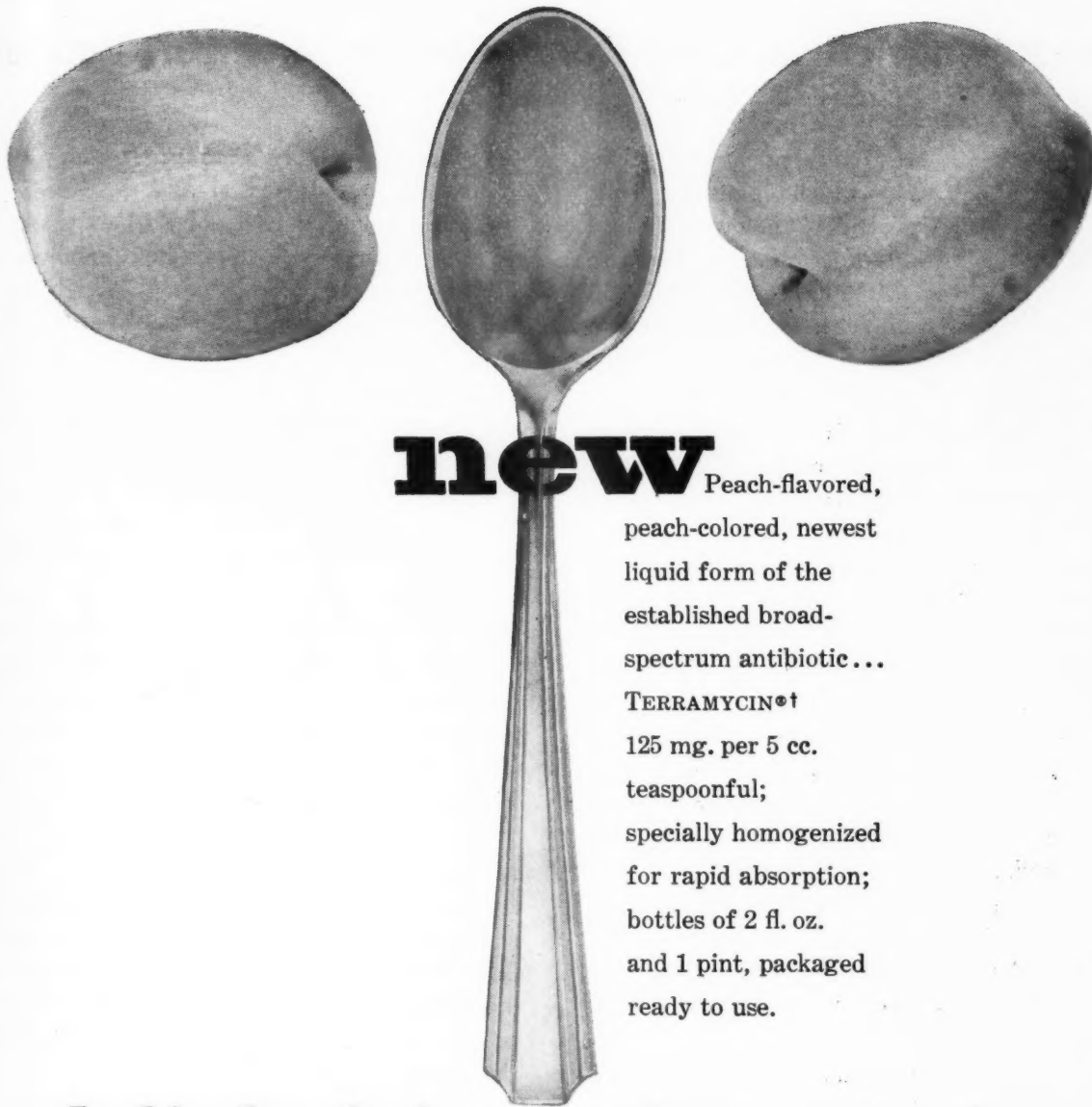
- **Financial reports** for the first quarter of 1956 were given study and approved. Bills payable were approved, and payment was authorized.
- **Veterans Administration's decision** to continue "Home Town Medical Care Program" in Michigan was reported. A letter of thanks was ordered dispatched to Veterans Administrator H. V. Higley for his judicious handling of this matter.
- **Governor's Commission on Prepaid Hospital Care Plans.**—The possibility of a prejudiced report that might well arouse the criticism of Michigan's 6,200 doctors of medicine was discussed. A communication was authorized sent to the Governor's Commission and to the Board of Regents of the University of Michigan urging a review of plans for this important study.
- **Committee Reports.**—The following were given consideration: (a) Permanent Conference Committee, meeting of April 14; (b) Committee on Health and Accident Insurance Policy Control, April 25; (c) Mental Health Committee, April 25; (d) National Defense Committee, May 2; (e) Committee on Arrangements for 1957 Michigan Clinical Institute, May 15; (f) Arbitration Committee, April 15.
- **Wm. A. Hyland, M.D.,** Grand Rapids, Chairman of Michigan's Delegation to AMA, reported on a caucus of Delegates and Alternate Delegates held this date and the discussion on numerous resolutions to be presented from Michigan and other states to the AMA House of Delegates, Chicago Session of June 10-15.
- **Appointments.**—E. F. Sladek, M.D., Traverse City, was appointed a member of the Committee on Michigan Medical Service.  
H. A. Furlong, M.D., Pontiac, was appointed as Chairman of Committee on Package Deals Between County Medical Societies and Local Welfare Departments. Members of the Committee are: W. W. Babcock, M.D., Detroit;

H. H. Hiscock, M.D., Flint; L. L. LeFevre, M.D., Muskegon; and H. W. Wiley, M.D., Lansing.

- **Rheumatic Fever Coordinator** Leon DeVel's monthly report was presented and approved.
- **Norman F. Miller, M.D.,** Ann Arbor, was invited to be Discussion Conference Leader (Friday, September 28) at 1956 MSMS Annual Session.
- **IBM Membership Billing for MSMS**—This electronic system, to be inaugurated on January 1, 1957, was outlined in detail, and the installation was approved.
- **Honor Received.**—Report was presented that W. S. Jones, M.D., MSMS President, recently had been made an honorary member of the Georgia State Medical Society (Dr. Jones' native state).
- **The monthly report of Public Relations Counsel H. W. Brennehan** included digest of recent state legislation.
- **A new Committee on Healing Arts Study,** composed of Arch Walls, M.D., Detroit, Chairman; B. M. Harris, M.D., Ypsilanti; and H. B. Zimmer, M.D., Lapeer, was appointed to offer recommendations, through the Council, to the 1956 House of Delegates, to streamline the present outmoded healing arts statutes.
- **The Council** requested that the individual Councilors hold district caucuses, between July 23 and September 23, to which should be invited Delegates, Alternate Delegates and County Society officers, for the discussion of pressing socio-economic problems.
- **Legal Counsel J. Joseph Herbert** presented opinion re problem in obtaining autopsies, as well as a progress report on the Kopprasch case.
- **Matters of mutual interest** were discussed with Michigan's Health Commissioner A. E. Heustis, M.D.
- **Wayne County Medical Society's new building,** and the current drive for funds, was discussed by W. B. Harm, M.D., who stated \$240,000 already has been raised toward the new building.

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JULY, 1956

Say you saw it in the Journal of the Michigan State Medical Society

767

## Hometown Medical Care Continues for Michigan Veterans



HARVEY HIGLEY

It is no accident that Michigan, which pioneered the Veterans Hometown Medical Care program ten years ago, is the only state which will continue to administer such a program through its Blue Shield Plan next year.

This is due to the outstanding record of efficient, smooth operation of the Michigan veterans hometown care program. And that is no accident either. It, in turn, is due to the joint efforts of the doctors of Michigan working through their state medical society, to the efficiency of their Blue Shield Plan and the solid support of all the veterans organizations.

Last, but not least, it is due to the hard work and the effective and convincing presentation of these facts to the leaders and top-policy-makers of the Veterans Administration in Washington this April by leaders of the Michigan State Medical Society, Blue Shield and the state's veterans organizations. That is the real story behind the continuation of the hometown care program through Blue Shield for the thousands of veterans in Michigan.

Nearly a year ago the Veterans Administration had set July, 1957, for elimination of the program as administered by Blue Shield Plans. It was the fine record of the Michigan Program, plus the hard-hitting presentation of it to Washington that led Veterans Administrator Harvey Higley to reverse that decision for Michigan. The evidence of its need and value was incontrovertible. He ruled in May after detailed hearings that the veterans hometown care program will be continued indefinitely in Michigan under the administration of Michigan Medical Service (Blue Shield).

The Veterans Administration arrived at its original overall decision to eliminate the hometown care programs throughout the country on the basis of its estimate of a saving of \$350,000 annually in administrative expense.

The VA's argument went something like this:

The hometown care program, which was vital right after World War II and the Korean War, had now stabilized to a point where in the main veterans with service-connected disabilities could be treated at regional VA clinics. It felt, too, that the dwindling number who were treated through their hometown doctors could now be handled administratively directly between the doctors and the Veterans Administration. There was no longer any need for the Blue Shield plans to act as the administrative agency between the doctor and the VA to process payments to the doctors.

However valid this argument might be for the other states, it simply did not hold water for Michigan. It did not reflect the actual facts.

There has naturally been some decline in the volume of medical care needed by Michigan veterans since the peak of the early years of the program. But it was far from enough to justify discarding the program.

Here are the facts: During the ten years the veterans hometown care program has been in operation in Michigan through Blue Shield, there have been total payments to doctors for care authorized by the VA to veterans of a shade under \$10,000,000. Even with the peak early years loading the average, this amounts to a little less than \$1,000,000 a year.

Yet in the fiscal year of 1955—Blue Shield made payments to Michigan doctors for care totaling \$860,000 involving 72,500 VA authorizations.

But that is only half the story. Those 72,500 authorizations last year had an average value each of \$16.06. But the average payment made to doctors per authorization was \$10.18.

In short, the average payment per authorization ran 36 per cent lower than the value of the authorization. And here is why: In many cases the authorization called for more services than the case actually required in terms of needed treatment. These figures are dramatic proof that the doctors of Michigan are rendering services strictly according to the veteran's needs. If fewer are needed than authorized, that is all the doctor performs and all the VA is charged for. The doctors

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## HOMETOWN MEDICAL CARE

(Continued from Page 768)

of Michigan, in fact, are acting voluntarily as the watchdogs of economy for the VA.

These were the facts—this was the story the MSMS leaders, the heads of your Blue Shield Plan and the heads of the state's veterans organizations took directly to VA Administrator Harvey Higley.

Part of that story—and a very important part that had a great deal to do with Higley's decision to reverse himself and reinstate the Michigan program—lay in the record of efficiency Michigan Blue Shield had chalked up in administering it.

Since the program was started in 1946, Michigan Blue Shield handled the administration and payment of \$10,000,000 involving nearly 800,000 services authorized for Michigan veterans by the VA.

Not only did the veterans receive prompt, needed medical care directly from their hometown physicians, but the administration of the program and the complex job of paying the doctors for this ten year period has averaged less than seven per cent. In fact, last year, the cost of administering the program through Michigan Blue Shield was down to 6.26 per cent.

These were the facts that caused the VA to change its mind so far as continuing the hometown care program in Michigan through its Blue Shield Plan was concerned.

But credit in large measure is due to Veterans Administrator Higley for his courage and forthrightness in reversing a top-policy decision when the easy way out would have been to ignore the facts.

William S. Jones, M.D., President of the Michigan State Medical Society, made that point very clear.

"Mr. Higley cannot be commended too highly for his wholehearted cooperation and willingness to hear and judge the facts objectively," Dr. Jones said. "In short, his attitude was 'show me I'm wrong and I'll change my decision. My basic interest is to see that the veterans of Michigan are assured the best possible method of receiving care within the boundaries of economical administration for the Veterans Administration.'"

Wilfrid Haughey, M.D., president of Michigan Medical Service (Blue Shield), said that the VA's decision to continue to administer the program

through Blue Shield in Michigan is recognition that this method "is still the best and most efficient way to provide medical care for veterans with service-connected disabilities."

He added that it was quite a high compliment and indicates that after careful study the VA found that the administrative efficiency and know-how of Michigan Blue Shield can best deliver good medical service promptly and economically to the thousands of Michigan veterans who need it.

That was the story back in 1946 when Michigan Blue Shield and Michigan doctors through the Michigan State Medical Society developed the program voluntarily to meet a crisis.

The Veterans Administration was not equipped to provide medical services through its own facilities to the large number of veterans with service-connected disabilities that needed prompt effective treatment.

It was the veterans hometown care program, developed by Michigan's doctors and Blue Shield Plan, that provided the desperately-needed solution. Through it, the veteran needed only the VA authorization for treatment to go directly to his hometown doctor for care.

The tremendous task of effecting payment to the doctors—reasonably prompt and fair payment—was solved by using the administrative facilities of the Michigan Blue Shield Plan.

Blue Shield agreed to perform this service for the Veterans Administration for no other consideration than the actual cost of performing the mechanics of the job.

The result has been and will continue to be:

1. Assurance that the veterans of Michigan receive good care promptly and through the existing and convenient facilities of their hometown doctors.

2. Assurance to the VA that veterans will get needed care with a minimum of trouble and red tape to them and at a minimum administrative cost to the VA.

3. Assurance to the doctors of Michigan of payment of these services through its administration of their Blue Shield Plan promptly, equitably and with a minimum of time-consuming filing of claims.

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It is a mark of intelligence, no matter what you are doing, to have a good time doing it.

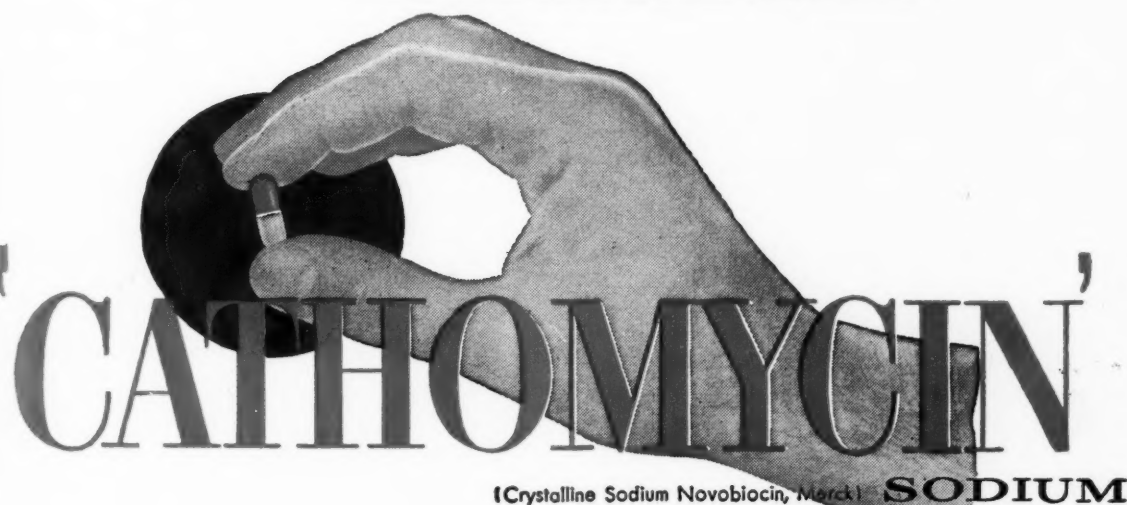
—Ben White Cochran

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## Howard Cummings, M.D., Honored

Presentation of the *Distinguished Medical Citizenship Award* to Howard H. Cummings, M.D., by the Northern Tri-State Medical Association, was made at the annual meeting in Ann Arbor, April 12, 1956.

In presenting the award, John M. Sheldon, M.D., spoke as follows:

It is a great pleasure and privilege to present this justly deserved Award to Dr. Howard H. Cummings, my teacher and chief. It would not be possible to mention all his wonderful attributes, or tell even a few anecdotes that concern my chief in the time allotted to me. I shall try to cover only a few.

This august assembly is well aware that Dr. Cummings served as your President in 1942-43, and that while he was at the helm he was untiring in his efforts in the interest of postgraduate medical education. You are also aware that he has continued to contribute much sound advice, help and support to the organization.

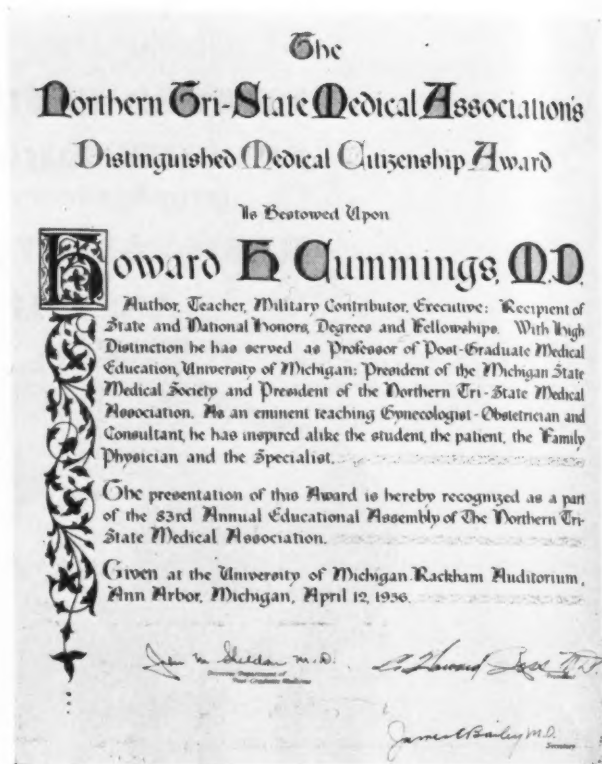
Dr. Cummings has also served faithfully and well in many other capacities. He was President of the Michigan State Medical Society in 1942-43, after having served as Councilor of the Society from 1933 to 1941. He has been a member of the Committee on Postgraduate Medical Education of the Society continuously since 1946.

Dr. Cummings received his early education in New York State, after which he entered the University of Michigan. At the end of his freshman year in Medical School, he spent the next year or two working for the President of an oil firm in Pennsylvania. We are fortunate that the lucrative oil business did not take precedent over Dr. Cummings' desire to be a doctor, and that he returned to the University of Michigan to graduate with the Class of 1910.

After graduation from the University of Michigan Medical School, he studied in the Obstetric Department at Johns Hopkins University. Upon returning to the University of Michigan, he was associated with the Department of Obstetrics and Gynecology from 1910 to 1913, and from 1917 to 1919. From 1913-1917, he was the executive head of the University Health Service, and contributed much to its development. He organized three ambulance units for service with the French Army in World War I, and served during the Second World War as a member of the Washtenaw County Appeal Board of Selective Service System.

In 1920, he entered the private practice of obstetrics and gynecology. He served as chief of that service at St. Joseph Mercy Hospital for many years, as well as chief of staff in 1942-43. He has an enviable reputation in his specialty and has contributed many articles to medical literature.

Among the professional and learned societies of



which he is a member are Alpha Omega Alpha, Sigma Xi, University of Michigan Research Club, the American College of Surgeons, and the Central Association of Gynecologists and Obstetricians. He is a Fellow of the American Academy of Obstetrics and Gynecology, of which he was one of the Founders. He is a Diplomate of the American Board of Obstetrics and Gynecology. He served the State as a member of the Michigan State Sanatorium Committee for many years.

Dr. Cummings has made an outstanding contribution to the educational program of the University in directing the co-operative efforts of the University of Michigan Medical School, the Wayne University College of Medicine, the Michigan State Medical Society and the Michigan Department of Health in the field of postgraduate medical education. He has appreciated fully the great value of, and given recognition to the excellent contribution which each of these institutions is making in the postgraduate medical teaching program for practicing physicians in many centers of the State. The program has long had national recognition and in 1948-49 Dr. Cummings served as secretary-treasurer of the Associated States Postgraduate Committee of the American Medical Association.

While he was Chairman of the Department of Postgraduate Medicine, both the extramural and intramural programs of postgraduate medical education have been

(Continued on Page 806)



**a pause for reflection . . .** Operation finished.

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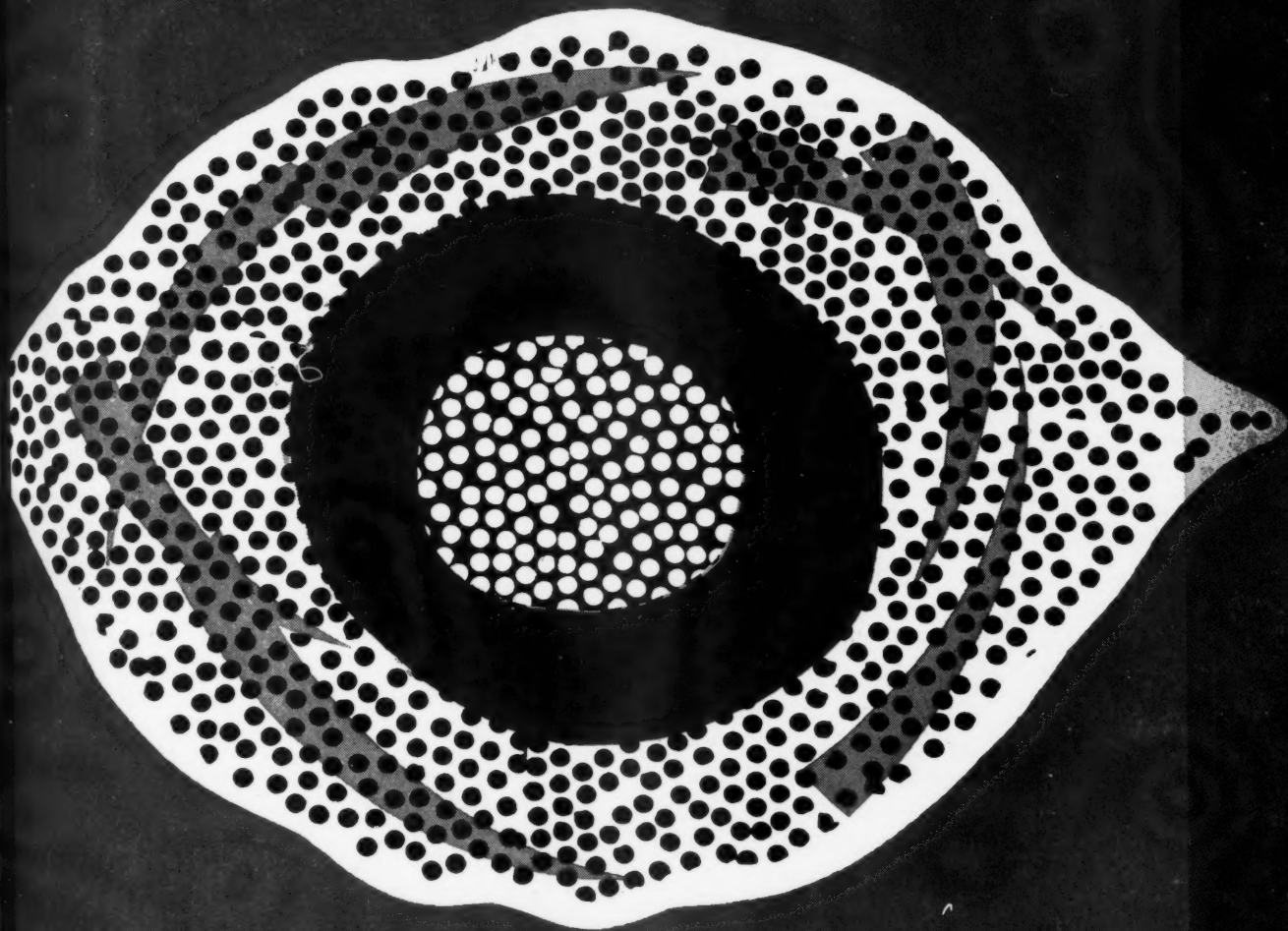
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## Heart Beats

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### **AHA ANNUAL MEETING AND SCIENTIFIC SESSIONS**

A tentative program has been outlined for the 32nd Annual Meeting and 29th Scientific Session of the American Heart Association to be held in Cincinnati, October 26-31. The Scientific Sessions will be conducted at the Music Hall auditorium beginning on Friday evening, October 26, and continuing through Monday, October 29. The organizational meetings of the Association will follow the scientific presentations.

The opening Scientific Sessions on Friday evening will be devoted to instrumentation. General sessions, to be held on Saturday, Sunday and Monday mornings, will include papers of the broadest general interest, while simultaneous specialized sessions in the afternoon will provide opportunity for the presentation of papers of particular pertinence to those whose primary interest is in the fields of basic science, circulation, clinical cardiology, hypertension, cardiovascular surgery, rheumatic fever and congenital disease, epidemiology and the community or public health aspects of cardiovascular medicine. There will also be a number of symposia and panels, including one devoted to cardiac rehabilitation, and two special lectures, the Lewis A. Conner and George E. Brown Memorials.

The Netherlands Plaza Hotel will be the AHA Headquarters during the annual meeting period.

### **REVISED DIAGNOSTIC GUIDE ON CONGENITAL DEFECTS**

A newly revised edition of the booklet, "Diagnosis of Cardiac Defects in General Practice," has been prepared for the American Heart Association by Regina Gluck, M.D., Assistant Clinical Professor of Pediatrics at Bellevue Hospital, New York.

The revision reflects the many advances in knowledge and in clinical experience with regard to diagnosis, management and treatment of congenital defects since the issuance of the prior edition in November, 1954. Particular attention is paid to the most recent developments in surgical correction of congenital anomalies.

Physicians may obtain copies from the Michigan Heart Association, Doctor's Building, 3919 John R, Detroit 1, Michigan.

### **BOOKLET AVAILABLE FOR PATIENTS WITH CORONARY DISEASE**

Revision of the American Heart Association's booklet "Heart Disease Caused by Coronary Atherosclerosis" has been completed by Paul D. White, M.D., Boston, and is now available for physicians who wish to distribute copies to their patients.

The booklet is particularly designed to aid the coronary heart disease patient in gaining an understanding of the physiologic and pathologic phenomena underlying his condition. Included is a section on "What the Doctor Tells His Patient." Copies may be obtained from the Michigan Heart Association, Doctors' Building, 3919 John R, Detroit 1, Michigan.

### **AHA TO REVIEW U. S. PAPERS FOR INTER-AMERICAN CONGRESS**

The American Heart Association will review all abstracts of papers by United States physicians and research scientists who wish to make presentations at the Inter-American Congress of Cardiology in Havana, November 11-17. This is in accordance with the regulations of the Inter-American Cardiology Society, sponsors of the congress. These regulations provide that papers must first be submitted to the national cardiology society of the country in which the author resides.

### **AHA MAKES WIDE DISTRIBUTION OF RHEUMATIC FEVER CRITERIA**

Distribution by the American Heart Association of reprints of the statement, *Jones Criteria (Modified) for Guidance in the Diagnosis of Rheumatic Fever*, to 183,000 practicing physicians and 25,000 medical students has been undertaken with the co-operation of the National Heart Institute of the U. S. Public Health Service and of the American Medical Association.

The statement was first published in September.

(Continued on Page 778)

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Supplied : White, 5 mg. oral tablets,  
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1. Johnston, T. G., and Cazort, A. G.:  
J. Allergy 27:90, 1956.
2. Schwartz, E.:  
New York J. Med. 56:570, 1956.
3. Schiller, I. W., et al.: J. Allergy  
27:96, 1956.

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## AHA MAKES WIDE DISTRIBUTION OF RHEUMATIC FEVER CRITERIA

(Continued from Page 776)

1955, issue of the AHA's monthly bulletin for physicians, *Modern Concepts of Cardiovascular Disease*. It is a revision of the widely-accepted rheumatic fever diagnostic criteria originally drawn up by the late T. Duckett Jones, M.D. The modified criteria are intended as a guide to the physician which will help him to avoid the dangers of either over-diagnosis or under-diagnosis of rheumatic fever.

Additional copies of the Jones Criteria statement can be obtained from the Michigan Heart Association, Doctors' Building, 3919 John R, Detroit 1, Michigan.

## HIGH BLOOD PRESSURE RESEARCH MEETING PROCEEDINGS PUBLISHED

The proceedings of the 1955 Annual Meeting of the American Heart Association's Council for High Blood Pressure Research, held in Cleveland last November, have been published in book form. The volume contains eight papers together with verbatim transcripts of ensuing discussions.

The proceedings offer a concentration of the latest knowledge in the field of hypertension, particularly with regard to its neurovascular aspects. Further information on the volume is available from the Association, 44 East 23 Street, New York 10, New York.

## AHA ISSUES GUIDE FOR BLOOD VESSEL BANKS

Recognizing that modern advances in the diagnosis and surgical correction of cardiovascular diseases have made procurement, preservation and implantation of blood vessel grafts an important factor in the success of such surgery, a committee

of the Scientific Council of the American Heart Association has drawn up a guide for establishment and operation of blood vessel banks.

The guide, "Recommendations for the Establishment and Maintenance of a Blood Vessel Bank," is designed to aid clinical investigators in the establishment of blood vessel banks under standard conditions and to encourage a "certain uniformity in the procurement and preservation of vascular grafts for evaluations."

In addition to its discussion of techniques involved in the utilization of vascular grafts, the guide also contains a section devoted to the various types of rigid and flexible plastic grafts, noting however that "only long-term post-operative observation in human recipients will give a definite answer on the fate of various types of vascular and plastic prostheses."

The guide also discusses the relative advantages of procurement of vascular grafts from the donor under sterile and non-sterile conditions. Sections are devoted to space requirements for banks, equipment, legal aspects of procurement, techniques, and evaluation of donor material based on age of donor, cause of death and interval between death and autopsy. Various types of sterilizing and preservative agents are described.

The recommendations for blood vessel banks were prepared for the Association's Scientific Council by a committee of four cardiovascular surgeons, Jere W. Lord, Jr., M.D., New York; Robert E. Gross, M.D., Boston; Charles A. Hufnagel, M.D., Washington, D. C.; and Abel A. Lazzarini, Jr., M.D., New York.

Single copies of the guide may be obtained by physicians from the Medical Director American Heart Association, 44 East 23 Street, New York 10. Information on procuring copies of the guide in quantity may also be obtained from this source.

## MEDICAL TELEVISION SHOWS Produced by Michigan Health Council

| Date         | Station               | Subject                            | Guests                           |
|--------------|-----------------------|------------------------------------|----------------------------------|
| May 3, 1956  | WKAR-TV, East Lansing | Hospital Gray Ladies               | Mrs. Arnold Hopperstead, Lansing |
| May 6, 1956  | WJBK-TV, Detroit      | Occupational Therapy               | Max K. Newman, M.D., Detroit     |
|              |                       |                                    | Barbara Jewett, OTR, Detroit     |
|              |                       |                                    | Jack Wilburn, OTR, Detroit       |
| May 10, 1956 | WKAR-TV, East Lansing | Hospital Week—Student Medical Care | Mrs. Catherine Sobieski, Detroit |
| May 13, 1956 | WJBK-TV, Detroit      | Medicine U.S.A.—The Living Proof   | C. G. Menzies, M.D., E. Lansing  |
| May 20, 1956 | WJBK-TV, Detroit      | Operation X-Ray                    | A Film (A.M.A.)                  |
|              |                       |                                    | Judge Frank Shemanske, Detroit   |
|              |                       |                                    | Nicholas DeJanney, M.D., Detroit |
|              |                       |                                    | Mrs. John Miller, Detroit        |
| May 24, 1956 | WKAR-TV, East Lansing | Michigan Cerebral Palsy Week       | Mark Brower, Lansing             |
| May 27, 1956 | WJBK-TV, Detroit      | Pesticides and Solvents            | Ralph G. Smith, Ph.D., Detroit   |
|              |                       |                                    | Mr. James MacEwen, Detroit       |

in respiratory allergies

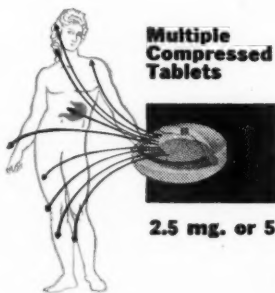
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and 300 mg. aluminum hydroxide gel.

References: 1. Boland, E. W., *J.A.M.A.* 160:613, February 25, 1956. 2. Margolis, H. M., *et al.* *J.A.M.A.* 158:454, June 11, 1955. 3. Bollet, A. J., *et al.* *J.A.M.A.* 158:459, June 11, 1955.

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779

## Social Security Disability Freeze

In recent months, many physicians have heard from patients about the disability freeze provision in the social security law. This provision, added to the old-age and survivors insurance program in 1954, permits people who have prolonged total disability to apply to have their social security records frozen for the period of their disability. Thus, the time when they could not work and so had no earnings credited to their social security accounts does not count against them in determining their rights to benefits, nor the amount of benefits which will be payable to them at age sixty-five, or to their families in case they should die.

Before a worker's social security record can be frozen, he has to meet certain work requirements. His social security record up to the time of his disability must show that he was in fact a worker, with a fairly regular and recent work history. In addition, he must be shown to have a medically determinable physical or mental impairment severe enough to keep him from engaging in any substantial gainful activity—one which has existed for more than six months, and is expected to last indefinitely or end in his death.

### Securing Medical Evidence of Disability

The medical evidence needed to establish the nature and severity of the applicant's disability, the date it began, and its prognosis comes from the doctor who has treated the worker and knows his case, or the hospital or institution in which the worker has been confined. A Medical Report form was designed to assist the physician in furnishing the needed medical evidence and to indicate the nature and extent of clinical detail which would be necessary. It is given to the applicant for the "disability freeze" and he is asked to have it filled out by the physician most familiar with his impairment. The form itself is modeled closely after the medical report used by major life insurance companies in their disability claims work. In adapting it for use in the "freeze" program, the recommendations of a Medical Advisory Committee were closely followed. This Committee, composed of well qualified representatives of the medical and related non-medical professions, gives advice and guidance to the

Social Security Administration on the medical aspects of the "disability freeze" program.

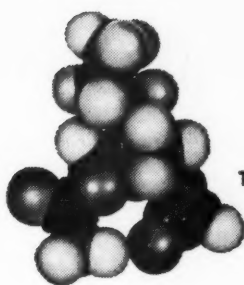
If you have received this medical form to fill out for any of your patients, you are probably aware that the law makes the disabled worker responsible for seeing that medical evidence is submitted for him and for paying any costs involved. The law does not permit the Government to pay any costs in connection with securing the medical evidence needed for a determination of disability. You may also know that to insure the confidentiality of the medical evidence, the medical report form is not to be returned to the patient, but is to be mailed by the physician direct to the local social security office. This office, incidentally, is ready to furnish additional information to the physician concerning the medical report form and the operation of the disability freeze.

### Determining Disability

Determinations as to disability based on the evidence submitted are made under an agreement with the Federal Government, by professional members of an agency of the State in which the applicant resides. In most States, this is the vocational rehabilitation agency. Since referral of disabled individuals for any rehabilitative services which might return them to gainful work is an important aspect of the program, each person applying for the social security disability freeze is told about the availability of vocational rehabilitation services.

On the professional team in the State agency at least one member is a doctor of medicine. The team reviews and evaluates all medical evidence assembled in the applicant's file, as well as such non-medical factors as age, education and occupational experience. Certain medical guides and standards, worked out with the advice of the Medical Advisory Committee are used in the consideration of the medical evidence. But, although these guides and standards can be applied in most cases, they are not rigid and arbitrary. The final determination in each case is based on all the available facts on the individual's impairment and vocational history, and,

*(Continued on Page 878)*



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# AMA Washington Letter

## THE MONTH IN WASHINGTON

Before the end of the year hundreds of thousands of dependents of military personnel, living in all parts of the country, should be receiving their medical care from private physicians and in private hospitals under the new program authorized this year by Congress. While Defense Department has not yet completed regulations to implement the act, the law itself lays down the basic principles governing the program.

The House Armed Services Committee first attempted to decide on a system or systems for furnishing private care, through Blue Cross, Blue Shield, arrangement with state medical societies, commercial insurance or "home town care," such as Veterans Administration successfully employs. But the committee gave up on the problem, and Congress finally tossed it to the Secretary of Defense by stating in the bill that he shall "... after consultation with the Secretary of Health, Education, and Welfare ... contract for medical care for such persons ... under such insurance, medical service or health plan or plans as he deems appropriate." A Defense Department task force now is attempting to decide how to work out the contracts.

Although several groups of dependents will be entitled to medical care, only wives (or husbands) and children of men on active duty will be certified for civilian care. The others will be admitted to military medical facilities on "availability of space" basis. While generally spouses and children of active duty personnel will have a choice of private or military care, there is this limitation: The Secretary of Defense may designate certain areas where private care will not be authorized, if in his opinion those areas have military facilities adequate to care for the service families.

Dependents will be required to pay the following charges: For care in military facilities, subsistence and "in-hospital" charges (set by Secretary of Defense and currently \$1.75 per day); for private care, the same fees or the first \$25, whichever is the larger.

The time limit on private care is twelve months, but if hospitalization still is required after this period the dependent will be protected. In this case the Defense Department will transfer the dependent to a military facility or will make direct payment to a private hospital.

Although regulations will spell out limitations and authorizations in more detail, the law makes the following provisions:

*Care in military facilities to include:* (1) Diagnosis, treatment of acute medical and surgical conditions, treatment of "contagious diseases," immunization and maternity and infant care. (2) Hospitalization for nervous and mental disorders, chronic diseases or elective medical and surgical treatments *but only in "special and unusual cases"* and for not more than twelve months. This would be provided at the discretion of the Secretary of Defense. Dental care not authorized except in unusual cases, while abroad or at remote stations in the U. S.

*Private care will include:* (1) Hospitalization in semi-private accommodations up to one year for each admission, including all necessary services and supplies furnished by hospital. (2) Medical and surgical care incident to hospitalization. (3) Complete obstetrical and maternity service, including prenatal and postnatal care. (4) Physician or surgeon's services prior to and following hospitalization for bodily injury or surgery.

Under the private care program, some services may be furnished outside the hospital, such as surgery in a doctor's office, x-rays or laboratory tests, "but not what is normally conceived to be out-patient care." If experience shows they can be afforded, additional services may be authorized, but whatever the scope of private care, it cannot exceed that furnished in military facilities. Out-patient care will be furnished by military facilities, but "uniform minimal" charges may be imposed as a restraint on excessive demands.

NOTES: Federal appropriations for medical research are at an all-time record, explained in part by Senate approval of a 48 per cent increase over last year's funds.

Dr. Lowell T. Coggeshall, special assistant to HEW Secretary Folsom, believes some "wise changes" should be made in medical economics to facilitate payment for the "spectacular" new medical services. He expressed his views in addressing a group at the University of Pennsylvania Medical School.

Russia and eight satellites, out of active participation in World Health Organization for more than six years, now are back in; they agreed to pay 5 per cent of past-due assessments over a ten-year period.

The highway program contains a provision for a one-year study of traffic safety, a problem in which the American Medical Association has been actively interested for years.

# The JOURNAL

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## Ear, Nose and Throat Symptoms Related to General Medical Conditions

By James B. Costen, M.D.  
St. Louis, Missouri

THE principal topic of this discussion, which will relate clinical problems of mutual interest to the general physician and the otolaryngologist, is fluid in the middle ear spaces. Uncontrolled otitis media became the chief interest of numerous authors early in the use of chemotherapy, Tobey<sup>1</sup> in 1942 pointing out new and difficult changes in diagnosis and treatment of ear infections after five years' use of sulfonamides. One question was whether to medicate early with saturating doses before thrombosis appeared in the smaller vessels, or whether to wait for some antibody reaction to occur. Virulence and variations in sensitivity of different strains of organisms to therapy was apparent from the first use of sulfonamides. Whether it was good practice to administer a drug to full therapeutic limits, in a disease which shows a tendency to recovery in 90 per cent of the cases under well-proven procedures, was a decision to make. Also, the variation in reports of cures, Tobey pointed out, coincided with epidemics and cycles of virulence.

Penicillin appeared, wider coverage of bacterial strains was possible, and uncontrolled medication for trivial ailments produced a great number of drug-sensitive persons. Development of numerous mycins further expanded the bacterial spectrum

susceptible to antibiotics. Bacteriological study of secretions and drug sensitivity tests of organisms assumed their vital role in treatment.

Actually it became clear at once that drugs given at random in certain types of infection had limited success. Henry and Kuhn<sup>2</sup> reported a series of 468 cases of middle ear infection, 47 per cent of whom would have received no benefit if bacteriological studies had not been made. Twenty-one important reports on this subject appeared before 1951, some giving emphasis to the need of surgical drainage in addition to antibiotics. Bilchick and O'Kane,<sup>3</sup> Williams,<sup>4</sup> and Hall<sup>5</sup> and others, in large series reports, pointed out the low incidence of mastoiditis requiring mastoidectomy in all cases receiving myringotomy, whether antibiotics were used or not. Evans<sup>6</sup> in 1951 reported a study of thirty-six mastoidectomies in thirty cases admitted from outpatient service, all of whom had inadequate antibiotic therapy, and *not one of whom had myringotomy*. Goodale and Montgomery<sup>7</sup> recently emphasized the need for myringotomy and selective antibiotic treatment, and reported cases demonstrating the dangers inherent in the nonsurgical concept of acute suppurative otitis media.

### Nasopharynx

Serous otitis, characterized by a collection of serous fluid in middle ear spaces, is sometimes extremely difficult to diagnose, because a casual

From the Department of Otolaryngology, Washington University School of Medicine, and the Oscar Johnson Institute.

Presented at the Michigan State Medical Society annual session, Grand Rapids, Michigan, Sept. 29, 1955.

JULY, 1956

glance at the ear drum reveals it perfect, or glistening clear. This condition is more common than ever before. There is probably no increase from rise in population, but serous otitis is recognized as a complication of allergy oftener than ever before.

It is axiomatic that frequent attacks of otitis media in children are based on the presence of enlarged infected adenoids. Just as important are the same enlarged adenoids in the allergic child who shows up badly in group hearing tests in school. Ear studies are advised by the teacher and the first examination may reveal nothing. There may have been no otalgia, and by the time the ear is examined, the fluid could have vanished. If completely full of fluid, the drum picture could defy the sharpest scrutiny; on a second or third look, however, a small bubble or fluid level gives the clue to serous otitis. This cycle is frequently found to have been present for months. The treatment is incision of the drum and aspiration of its contents. No other procedure is adequate. So adenoids and allergy appear to rank all other sources of serous otitis. But a fast growing claimant may have already exceeded all other sources, and this is unresolved otitis media of infectious origin.

Before the antibiotic era, incision of the ear drum was the only certain means of treatment, and almost all acutely infected ears were treated by the otologist. With the universal use of antibiotics, most earaches subside with the general infection for which the drug is used.

The material which remains in the middle ear after quick sterilization of otitis media with antibiotics is not exactly serous fluid. It is probably sterile or liquefied pus. The effect on hearing is the same. The usual story is the patient presenting himself at the office, or even describing an earache over the phone. A large repository dose of penicillin is given by hypodermic, or oral antibiotics ordered to be taken until the patient can come for examination. The patient is promptly relieved. If adult, he reasons that the pain is gone, he is busy, and the stuffy sensation and ringing tinnitus are to be expected; if a child, the pain is gone, the temperature gone, therefore the need of further inspection is minimized. The doctor is thereby exonerated, so is the patient. The flaw really lies in the natural trend of wonder-drug medication. The problem is taken up weeks or months later,

when deafness persists, and fluid is found in the ear.

The third large competitor to allergy and antibiotics for top etiological rating is the airplane. Numerically the number of ears subjected to strong negative pressure would probably exceed them all, if counted. After the plane ride, however, the patient has pain, in addition to a middle ear full of serous fluid, seeks the otologist promptly, and is promptly relieved by myringotomy. In all three types the affected ear is deaf; there is a constant ringing noise in it, and the voice roars into that side because of the Weber phenomenon. Comparison of the affected ear to the opposite side may show it perfect, the fluid behind it giving no hint of its presence except when a level or the outline of bubbles can be seen. Examination of the normal ear shows a clear bluish texture, and the serous ear has a waxy sheen; the stapedo-incal junction is not seen in the fluid ear and is clearly seen in the unaffected ear as a V-like shadow in the upper posterior half.

Nasal sprays and inflation of the eustachian tube may relieve the condition, but nothing takes the place of incision of the ear drum. Even when using antibiotics, nothing takes the place of incision for middle ear abscess, and no other single step is as important in shortening the course of infection, preventing residuals and saving the hearing. Surgical drainage here is just as important as any other spot in the body and cannot be replaced by antibiotics. Incision of the ear drum never did any harm to any ear, but neglected middle ear fluid or infection has made millions of middle-aged people deaf.

Not all problems of the nasopharynx are resolved in these classic reactions. Behind some examples of serous otitis lies the ominous chance of a malignant lesion. Many needless biopsies of the area next to the eustachian tube may be done but rewarded now and then by diagnosis of carcinoma, lymphosarcoma or even tuberculosis.

### Base of Tongue

The occurrence of neurosis in a patient implies anxiety, obsessions, fears and phobias. In the list of complaints, palpitation, rapid breathing, and choking sensations are common. In milder types with less obvious mental reactions, choking, tiring of the throat and "lump" in the throat from the group of symptoms revealed to the physician. It

is usually called globus hystericus. In 1937 Saunders<sup>8</sup> classified the symptoms as a pharyngeal neurosis, ascribed it to spasm of the motor nerves, and stated that it is due to enlargement of the lingual tonsil, or to lingual varicosity; that the treatment is mental, with correction of the causative factor. During an era when the public is strongly admonished to report any lump for early diagnosis, these anxious patients besiege throat doctors for reassurance.

Treatment of the mental condition is psychotherapy, reassurance and sedation. Removal of lingual tonsil masses is followed by extremely severe painful reaction in the tongue and is done only on the strongest indication. However, for lingual varices, which are the commonest source of the "lump" sensation at the base of the tongue, a simple, effective treatment may be used. It consists of application of a strong solution, almost coagulating strength, of silver nitrate. The throat is anesthetized with 1 per cent pontocaine, and 25 per cent silver nitrate is applied cautiously to the lingual veins. Laryngeal spasm is rare if the curved applicator is dried before use, and the application is guided by mirror vision. The treatment is repeated monthly for a few times, after which the patient returns only at long intervals. A high percentage of anxious, neurotic patients are relieved when this is demonstrated as the origin of the "lump" sensation.

Another class of tongue symptoms is chronic soreness, vague, constant, but definitely localized to an area on the base. It is easily acceptable as chronic tonsil infection. Mirror examination shows an embossed irregular gray patch surrounding and involving the lingual tonsil structures. Biopsy reveals typical actinomycosis. It promptly improves on potassium iodide and mycostatin. Many such foci of actinomycosis are found in routine tonsil sections.

Reviewing in rapid sequence carcinoma, lymphosarcoma and plasmocytoma found on the base of the tongue, many are large before suspected.

One of the most important and neglected diagnostic features of the thyroid is the age of the patient. In patients under forty, any history of sudden increase in size or pressure, change or loss of voice, firmness of consistency, or fixation to surrounding tissue should be regarded as an indication for immediate surgery.

Human anatomy continues to be the biggest obstacle to the cure of cancer of the esophagus.

*Mirror laryngoscopy, used as routinely as the tongue depressor, will uncover many a lesion as small as the vallate papilla. We owe this simple routine to every patient for his chance of survival.*

Summarization is not important in this sweep from the nasopharynx to the base of the tongue. It is sufficient to emphasize the need of searching these areas, for lesions which are not rare or remote but common when recognized by careful examination. One glance at the base of the tongue quickly reveals a simple lingual varix or more important lesion.

A very small percentage of school children handicapped by deafness belong to nerve deafness groups which require special audiological training. The largest fraction by far are those with conductive lesions. Antibiotic treatment *with myringotomy* will remove most of the serious destructive ear infections. Antibiotic treatment *without myringotomy* will contribute mastoid complications and many examples of incompletely resolved ear abscesses to the elusive and large class of serous otitis deafness.

3720 Washington Boulevard

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Out of 5,000 thyroidectomies for nodular goiter at the University of California Hospital, 300 carcinomas were found.

It has been proved that thiouracil will produce tumors in the animal thyroid.

When at all practical, surgery is the treatment of choice for thyroid cancer.

# Endometriosis

By Leon S. McGoogan, M.D.  
Omaha, Nebraska

## Etiology

THERE are numerous theories as to the etiology of endometriosis. One theory or another may be valid in different instances. In some cases the endometriosis may arise from transplantation of the endometrium to a new area by way of retrograde peristalsis of the tubes, or by trauma such as at the time of surgery. In other cases the explanation of origin can be found in metaplasia of coelomic epithelium, growth of congenital rests, or transposition by way of the lymphatic or venous channels.

Endometriosis occurs in the reproductive age of the female, occurring usually at the age of twenty-six years or later. It is infrequent under the age of twenty-six. For some unexplainable reason, it is more common in women of the private patient status than in those of ward or clinic status. Miegs<sup>9</sup> states that the ratio is approximately 4.5 to 1. He has suggested that the private or well-to-do young women marry later in life, reproduce late in life and that late reproduction may be a factor in the higher frequency of disease process in the well-to-do financial group. The frequency of endometriosis in the over-all female population is not known, but in women who are subjected to pelvic operations the incidence will vary from 17 to 35 per cent, depending upon the completeness of the observation of the pelvis, the keenness of the observer in recognizing and recording what he sees, and the diligence of the pathologist in demonstrating the pathologic process present in the tissues submitted to him.

## Pathology

Any structure in the reproductive group of organs—uterus, tube and ovary—may be involved. Adjacent or distant structures such as the colon, the bladder or the appendix may be the site of the process. The abdominal wall and the umbilicus have been frequent sites of endometriosis. Gross inspection of the structures in the pelvis at

the time of operation may reveal bluish to blue-black implants in the pelvis, varying in size from that of a small pin point to as large as 8 to 10 cm. in diameter. These structures are filled with a black, tarry substance. The larger endometriomata occur in the ovaries, and those in the other organs are usually less than 5 mm. in diameter. Endometriomata are subjected to, and may respond to, the various hormonal influences occurring in the female body from month to month during the period of life from menarche to menopause. The cyst-like structures enlarge from month to month. This is due to the accumulation of menstrual-like fluid which is produced by the ectopic endometrium at the time of the cyclic menstruation from the uterus. As the amount of menstrual-like material increases in quantity, the structures increase in size. They may rupture, allowing the accumulated material to pour into the peritoneal cavity and set up an inflammatory reaction, or they may rupture into another structure, one coalescing with another and producing a larger cyst-like structure. Organs or surfaces of other structures that are contiguous to the areas involved in endometriosis become adherent one to the other and at the time of operation no sharp cleavage lines are found.

Careful examination of the tissues removed at the time of surgery will show on microscopic examination endometrial-like glands, which frequently show a pattern of hormone influence resembling that of the endometrium.

Since the ectopic endometrium apparently reacts to the same hormonal influences as normal endometrium, one would pre-suppose that whatever influence might produce carcinoma of the endometrium might also under certain circumstances produce carcinoma in ectopic endometrium.

Primary carcinoma arising in ectopic endometrium in the ovary has been recently reviewed by Scott.<sup>13</sup> He found twelve cases in the literature and reports an additional proven case and two cases in which the origin of the cancer for an ectopic ovarian carcinoma is suggested but not proven. Two additional proven cases have been reported by Dockerty<sup>3</sup> and two more by Mancusi-

Presented at the Michigan State Medical Society annual session, Grand Rapids, September, 1955.

From the Department of Obstetrics and Gynecology, University of Nebraska College of Medicine.

Materi<sup>8</sup> and one by Postoloff and Rodenberg,<sup>11</sup> bringing the total to eighteen. Dockerty<sup>4</sup> reported two cases of adenocarcinoma of the recto-vaginal system probably arising from endometriosis and found five others in the literature. The total number of cancers proven to have had their origin in ectopic endometrium is twenty-five. External endometriosis can be considered to be at least as potentially capable of malignant transformation as normally located endometrium but the incidence is low.

Pregnancy can occur in the presence of endometriosis<sup>5</sup> and under the influence of pregnancy the ectopic endometrium undergoes decidual-like changes which resemble those occurring in the endometrium of the uterus.

### Symptoms

The symptoms may vary from none at all, and sterility, to varying degrees of menstrual menorrhagia, dysmenorrhea, dyspareunia, backache, constipation and pelvic pressure. Numerous women are found to have evidence of pelvic endometriosis on examination but without any symptoms.

Sterility as a symptom is difficult to evaluate, but about 30 to 40 per cent of married women with endometriosis will give a history of involuntary sterility.<sup>7</sup> On the other hand only about 3.5 per cent of patients who have a primary complaint of sterility will be found to have endometriosis.<sup>7</sup>

The menstrual pattern may be altered by lengthening of the cycle, profuseness of the flow or by both. These symptoms are more likely to be present with ovarian endometriosis or with uterine adenomyosis.

Dysmenorrhea, when present, is characterized by its occurrence in the latter half of the menstrual flow and persistence after menses cessation. Dyspareunia may be the patient's only complaint, and her presence in the office is often due to the insistence of her husband rather than to the discomfort of the patient.

### Diagnosis

The clinical diagnosis of endometriosis may be difficult, some authors reporting as high an error as 80 per cent. How can one reduce this percentage and improve his diagnostic acumen? If one adheres to the tubal transplantation theory of the origin of endometriosis, then the transplanted tissues should tend to find lodgment in the most

dependent portion of the pelvis, that is in the cul-de-sac and adjacent areas of the uterosacral ligament. Palpation of these areas by both vaginal and rectal routes will frequently reveal nodules in the areas. These nodules are fixed, approximately pea-like or smaller in size, and painful. The ovaries may be fixed and may be enlarged and tender. The uterus may be retroverted and retroflexed and adherent as well as tender. In those uteri which are the site of an adenomyosis the uterus may be nodular or uniformly enlarged.

Direct visualization of the cul-de-sac may reveal the bluish nodules behind the cervix. Direct intra-peritoneal visualization by the peritoneoscope or by the cul-de-scope may be of great aid. Finally direct inspection at the time of surgery may reveal the cause of the patient's pelvic complaints and allow the surgeon to alter his diagnosis from the preliminary preoperative diagnosis of pelvic inflammatory disease or other suspected pathology. Unless the tissues removed are carefully examined by the pathologist, a clinical diagnosis of endometriosis may not be confirmed by the pathologic examination. Suspect tissues should be reviewed by the surgeon and the pathologist together, and by this co-operative venture there will result a higher percentage agreement of diagnosis. The reverse of course may be true, and the pathologist may present to the surgeon a diagnosis of endometriosis in tissues in which he did not expect that diagnosis.

### Treatment

The non sympathomatic, minimal extent, cases of endometriosis should be observed and subjected to routine evaluation once every four to six months. Therapy of a definitive nature should be instituted only when the severity of symptoms or the extent of the disease process warrants such procedure.

### Medical Therapy

Stilbestrol has been used and has been recommended by Karnaky,<sup>6</sup> and he reports excellent results. Preston and Campbell<sup>12</sup> and Creadick<sup>2</sup> have both used methyl-testosterone. In their cases of sterility was a primary symptom and in those cases in which the male was fertile and all other factors possibly contributing to the sterility were corrected or eliminated, 60 per cent of the patients achieved a pregnancy. If the extent of the process is great, symptoms severe or incapaci-

tating, and child bearing not a factor in the patient's future, it might be wise not to employ medical therapy but to recommend or resort to a more radical approach to the problem by the employment of surgery.

### Surgery

The surgical treatment of endometriosis is generally accepted as the most prevalent therapeutic approach today. The surgeon is presented with varied and perhaps difficult problems. He should be as radical as necessary, but conservative enough to preserve the reproductive capacity of the patient. Partial resection of the ovary or ovaries should be done even if only a small portion of ovarian tissue remains. If one ovary is so badly involved that resection is impractical, and even if the other ovary is also involved, then partial resection of the remaining ovary is almost mandatory. The cortex of the ovary should be preserved, and all sutures should be of very fine catgut.

The uterosacral ligaments are frequently the seat of endometriosis. Resection of these ligaments is often not too difficult and should be done.

Retroversion, frequently due to pelvic adhesions subsequent to endometriosis, is to be corrected by a method which will correct the retroversion, not interfere with a subsequent pregnancy, and not recur following delivery. Suspension of the uterus should be a part of the operative procedure in those instances in which, in the opinion of the operator, postoperative adhesions might form and produce a retroversion. Presacral neurectomy may be indicated if the patient has dysmenorrhoea, and the pain is in the mid-line.

### X-Ray Therapy

The ablation of ovarian function may be very useful in those instances in which there is recurrence following surgery or in which surgery is contraindicated or medical therapy unsuccessful.

### Prognosis

In all patients subjected to surgery with the conservation of some pelvic function there is a recurrence of symptoms in about 6.9 to 9 per cent.

Reproduction is possible. Approximately 55.6 per cent<sup>7</sup> of all cases operated for a primary complaint of sterility will accomplish a pregnancy, although Norwood<sup>10</sup> recently reported that of fifty-four patients operated upon, fifty-one (94.4

per cent) became pregnant. About 30 per cent of all patients who have conservative operative procedures, regardless of whether they have a primary complaint of sterility or not and there are no other causes for sterility, become pregnant. The number of patients who become pregnant following testosterone therapy on the average is slightly greater than those subjected to conservative operative procedures, that is 60 per cent. Perhaps the mild cases of endometriosis should have medical therapy, and surgery should be reserved for those who have more severe symptoms or more extensive pelvic involvement.

As mentioned previously ectopic endometrium reacts, as all normal endometrium does, to the various hormonal changes that occur in the female from month to month, and it can undergo malignant change. The possibility must be remembered, but from a practical viewpoint the incidence is so low that the possibility of malignant change should not become a factor in deciding upon conservative or radical management.

Pregnancy can occur in the presence of endometriosis, but the incidence is infrequent and the pregnancy apparently causes a disappearance of the endometriosis process.

### Summary

The incidence of endometriosis is apparently four times greater in the private patient than in the ward patient. Its attendant symptoms are sterility and from no symptoms at all to varying degrees of dysmenorrhoea, dyspareunia, backache, constipation, and meno-metrorrhagia.

Diagnosis is difficult and missed in a high percentage of patients. Few errors will occur with adequate history and pelvic examinations. In the mild cases a medical regime with stilbestrol or testosterone may be of value. Whenever surgery is performed an effort at conservative therapy with preservation of the reproductive functions should be attempted. Surgical failures, which occur in from 6 to 9 per cent of cases reported, may be treated with deep x-ray therapy.

Sterility is a symptom in about 30 to 40 per cent of the patients, but endometriosis as a factor in sterility is very low, occurring in only about 3.5 per cent of the patients with sterility problems. If all sterility factors are evaluated and the male is determined to be fertile, 60 per cent of the

(Continued on Page 827)

## Therapeutic Abortion

By S. A. Cosgrove, M.D., F.A.C.S.

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**A**BORTION broadly is one of the serious problems of our national life. It is destructive of many thousands of immature human beings and is the cause of death of countless women all over the country, thus constituting what Greenhill has called one of the most dangerous operations in the whole obstetric-gynecologic field.

It is commonly considered among physicians as most regrettable and reprehensible, so that no ethical physician will engage in it in its most common and so-called criminal aspects. Many responsible and thoroughly ethical physicians, however, do employ it in a so-called "therapeutic" sense. Abortion is utilized by these men usually wholly honestly, in a manner whereby the criminal aspect of the operation is negated by the assumed necessity for it. This necessity is usually concerned with various disease conditions in the mother which occur during the pregnancy, which is interrupted. Sometimes, however, her interest is based on what are thought to be necessitous economic and social reasons.

Some years ago I became disturbed at which seemed to me to be the widespread abuse of so-called "therapeutic" abortion. So in 1944 Carter and I pointed out what we believed to be the altogether too frequent use of it generally all over the United States. In the discussion of this belief we postulated what Charles G. Child, Jr., had stated in 1931, that:

1. Physiologically, the unborn human being at any time after conception is an entity with all the life potentialities of any other creature.

From a scientific standpoint this postulate is hardly debatable. Although there is legally considerable variation as to whether the unborn human being is to be considered a specific individual, the laws of practically all of our American jurisdictions recognize the procurement of abortion in broad terms as illegal and punishable by various penalties.

2. The unborn human is entitled to the pro-

tection of those life potentialities as surely as is any other human being.

This postulate quite naturally and necessitously follows the acceptance of the first.

3. It is the duty of the medical profession to save and conserve human life. But effort to do that must not deliberately and of itself jeopardize the life of another individual, nor even the same individual.

It is upon one's concept of the truth of this postulate as to whether or not the sacrifice of one individual, that is, the fetus, is justified in order to save the life of another individual, that is, the mother. We believed then and still believe that it is not.

4. The deliberate and intentional interruption of fetal life, before the fetus is able to survive outside the uterus, is actually murder.

The statement of this postulate at the time was somewhat of a bombshell and was received with a good deal of criticism and incredulity. We were especially criticised for our use of the word "murder" in this connection. Several commentators at the time said that it was too harsh a term. Several other commentators then and since have urged that by legal definition "murder is the unlawful killing of a human being with malice aforethought, expressed or implied." One commentator says, "the distinguishing characteristic of murder is malice aforethought. Where it exists, the homicide is always murder. When it does not exist, the homicide cannot be murder, but is either manslaughter or excusable homicide." Whether or not the performance of abortion under any circumstances is attended with "malice" toward the fetus, it certainly is not characterized by any feeling of loving solicitude for the defenseless little creature. The choice of words is thereby obviously rather academic, but I am perfectly willing to change it, in the present discussion to homicide.

In the past decade, however, there have been numerous publications concerning this matter, and interest in it is still keen. There has been a rather widespread scrutiny of the necessity of ther-

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apeutic abortion all over the country, and many commentators of eminence and authority are coming more and more to believe in the postulates which we presented eleven years ago. We further said:

Under certain very limited circumstances homicide may be excusable. These circumstances generally accept its justification only to save another life certainly and imminently in danger.

These considerations limit the justification for the homicide, which we believed "therapeutic" abortion to be, to cases in which the pregnant mother's life is certainly and imminently endangered by the existence of the fetus, and its continued growth.

Contrary to much honest medical opinion and practice at the time, but on the basis of a very wide clinical experience, we showed that such danger was extremely rare.

Further on the basis of the definitions stated, abortion is never justified for (1) remote threat to the mother's life, (2) threat to her future health, or (3) any socio-economic considerations.

Review of our clinical experience we believed showed that the natural course of even very serious disease is almost never significantly altered by pregnancy. If it is, careful medical management better meets this risk than does abortion. And abortion itself is not infrequently (about 5 per cent) directly fatal to the mother in whose supposed salvation it is used.

This direct mortality in mothers is by no means negligible. It would be considered high in almost any but the most serious types of surgery. Another phrase of Eastman's is most significant and worthy of emphatic quotation as follows: "The more urgent the physical indication for 'therapeutic' abortion, the greater the contraindication because of the hazard imposed by the operation."

Therefore, it remains for our purpose only to discuss the disease conditions in the mother which allegedly constitute an imminent threat to her life, and from which therapeutic abortion would surely and inevitably save her. In this connection, Russell very well says "the medical indications for termination of pregnancy are becoming increasingly rare. The advances in modern medical and obstetrical knowledge remove from the category of accepted indications most, or possibly all, of the complications of pregnancy. However, it is felt the approach to the problem should be through the medical aspects, the dissemination of

medical knowledge, the application of advancements in medical treatment, and the institution of improved methods of evaluating cases presented for therapeutic interruption of pregnancy. The enlightened physician may then proceed with the proper scientific management of his case, usually without interrupting pregnancy, but certainly finding it unnecessary to resort to religious dogma or moral justification as the basis for his medical opinion."

I am perfectly willing to accept this fine statement as indicative of what we endeavored to propound in our original paper and at this time. Certainly we at all times have specifically ruled out religious dogma as the basis of our own belief. Just how certain fundamental moral values may be divorced from the thought and practice of us who have subscribed to the Hippocratic Oath, and who have tried to conduct our practice with the honesty of intelligence and judgment which our duty as physicians enjoins upon us all, I do not know. I very certainly do not wish to impose my own personal moral concepts on anyone else, and will freely concede that such moral aspects as enter into the matter must originate in the conscience of each individual doctor. But I must, I think, insist that each individual propound those questions which Eastman has stated and Russell has implied, rather than be too frequently misled by a mistaken and sometimes maudlin sympathy with the broad socio-economic problems of the pregnant woman. I am reminded of the breezy individual who entered my office many years ago saying, "Doctor, I want an abortion. You need not be concerned with any conscientious scruples about doing it, because I will freely accept the moral responsibility of your act." Like all physicians, I have been confronted with many pitiable situations, and undoubtedly have been many times accused of misunderstanding and lack of sympathy in meeting these problems. But as Rongy, one of the most radical commentators, said, "I have made certain of holding inviolate the dictates of conscience . . . as a practitioner of medicine."

Also I desire to warn that the individual obstetrician must be the sole judge of the dictates of his conscience, and not lend himself as a mere artificer to carry out the advice of even the best qualified men in other fields of medicine in meeting these questions. I recently had two cases of Hodgkins disease referred to me for abortion from

a clinic specializing in malignant and allied diseases because, forsooth, the regulations of their particular hospital did not permit the operation to be done there. Needless to say, those operations were not done by me nor in my hospital, and they resulted in completely successful deliveries of healthy babies without demonstrable damage to the mothers who were the victims of the disease for which the operation had been advised. Some years ago it was a matter of my knowledge that one leading obstetric clinic rather slavishly aborted patients on the say-so of the cardiologists associated with that clinic. Certainly in former years the phthisiologists were quite in the habit of insisting that obstetricians carry out their recommendations as to termination of pregnancy in women suffering from tuberculosis. Such subordination of the judgment of the man who is responsible for the life of the patient subjected to this operation should not be tolerated.

Of the most frequent conditions for which abortion has been therapeutically employed in previous years, there is almost complete agreement that hyperemesis gravidarum has ceased to justify it. I recall in my personal experience only two operations done for this indication. The first, many years ago, did not succeed in saving the patient's life. The second resulted in recovery, but when she presented a year or two later an even more severe picture of life-threatening toxemia than she did on the occasion on which we aborted her, we withheld abortion; she recovered, carried to term, and has subsequently delivered several other children without complication.

The toxemia of pregnancy is an ever-present problem to the obstetrician. Certainly we concur with the general opinion that severe toxemia of pregnancy warrants interruption of pregnancy. However, it seldom occurs early enough in the course of pregnancy to necessitate consideration of therapeutic abortion as we have defined it, that is, termination prior to the period of utero-gestation in which the baby is at least possibly capable of surviving its intrauterine existence. When it does occur before the so-called period of viability, by careful hospitalization, and proper medical treatment, resort to this expedient may be postponed until it ceases to constitute definitive homicide in that the baby is wholly incapable of surviving it. Moreover, our own experience would not lead us to believe that a mere history of prior acute pregnancy toxemia, even in its gravest forms, justifies abortion of a succeeding pregnancy.

In the consideration of fixed hypertension antedating the pregnancy or severe hypertension arising early in the pregnancy, as well as in many other medical complications of pregnancy, it must be borne in mind that the life-expectancy of the mother is very much impaired in any case whether pregnant or not. In them the persistence of pregnancy would have little effect on the course of the disease and the same would be true of artificial interruption of the pregnancy. Hypertensive disease does apparently carry a certain few special hazards with reference to the pregnancy, but even these hazards can be appropriately met in our modern regime of prompt obstetrical operative interference, the wide availability of blood sources for transfusion, et cetera. Moreover, as Eastman points out, these women are peculiarly susceptible to death of the fetus in utero spontaneously, with its expulsion by natural mechanism without involving the risk of artificial termination and evacuation. Those patients with hypertensive disease which do not show superimposed toxemia of pregnancy as the pregnancy advances can generally be safely carried to term without artificial interference. They should, of course, be most carefully watched for evidences of the additional occurrence or superimposition of real pregnancy toxemia. Should this occur, however, as indicated above, the pregnancy may be terminated in them by the application of the same principles as applied to toxemia itself at a period of gestation beyond that which would inevitably mean the death of the fetus.

We have learned from a very wide and carefully studied experience that heart disease in pregnancy does not warrant the employment of abortion, certainly where community and hospital resources permit their adequate treatment during the course of the pregnancy. This treatment should be most careful and strict as we have elsewhere outlined. I am ready to concede that such management may be exceedingly difficult where an ideal environment does not exist, and that there may under such conditions have to be a sacrifice of the ideals which I am trying to emphasize as proper, in the management of pregnancy complicated by heart disease and other severe medical conditions. However, it must not be forgotten that these patients especially are susceptible to the immediate hazards of the operation, and that heart disease patients in whom the pregnancy is terminated early do not do nearly so well as those having heart disease complicating pregnancy under the ex-

pectant treatment which we advocate under ideal conditions. In other words, sacrifice of the ideal objective for necessitous environmental factors may be disappointing and hazardous.

There is increasing awareness that pregnancy *per se* has little effect on the natural history of pulmonary and other forms of tuberculosis. The increased resources of cure of these conditions by medical and surgical means, all applicable during pregnancy, has removed tuberculosis from the category of disease justifying abortion.

As to actual malignant diseases, these, like other medical and surgical conditions, should be treated according to medical and surgical necessity without relation to the pregnancy. Thus, malignant processes of the female genitalia may involve by extirpation or by radiation the incidental destruction of the fetus. The very serious imminence and certainty of threat of life of the mother represented by these diseases certainly constitutes justification for the destruction of the fetus if perchance that is an inevitable consequence of the surgical treatment of the malignancy. Malignancies in other parts of the body may be appropriately treated by extirpation, radiation or other means without regard to, or disturbance of the co-existing pregnancy.

Neuropsychiatric disease appears now to be in the equivocal situation that tuberculosis was only a few years ago. Many authorities in this field believe that certain diseases of the central nervous system, and especially well-defined psychiatric disease, prohibit the continuation of pregnancy in the victims of those conditions. The issue, however, is not clear-cut. I believe that the evidence indicates, as already pointed out in relation to other types of disease, that the infective and degenerative diseases of the central nervous system are not affected in their natural history by the co-existence of pregnancy, nor benefited by the termination of such pregnancy.

In regard to psychiatric states, there is a serious conflict of experience and opinion. We have ourselves seen a number of cases in which patients suffering from earlier postpartum psychoses of undoubted identity, successfully go through subsequent pregnancy without recurrence of the psychiatric disturbance. Moreover, many psychiatrists concede, and obstetric authorities like Eastman have pointed out, that the malign influence of abortion, in the form of a guilt-complex in those patients with insight enough to appreciate the

meaning of the operation, is often deleterious to their subsequent psychiatric state. It is entirely possible that the risk of such psychic trauma more than offsets the problematical benefit of termination of the pregnancy in a group of diseases which, like so many others, tend to remission and recurrence and are prone to follow their own pattern no matter what particular mechanism triggers the ups and downs of their clinical course. It is highly probable that as increased therapeutic resources applicable to these diseases develop, they, like the others that I have previously discussed, will be automatically removed from the category of conditions which have heretofore been unquestioned as constituting indications for abortion.

Our own continued experience since 1944 serves to confirm our representations expressed then.

In the eleven years since then, no abortion has been performed in the hospital which I until recently directed.

Eastman suggests that if every physician confronted by this problem would answer the question conscientiously as to whether or not it seems "reasonably apparent in the patient under consideration that continuation of pregnancy will carry with it imminent danger of death or of great bodily harm," the abuse of therapeutic abortion, avowedly widespread, would be minimized. This question must also be conscientiously considered and answered by the various review boards now rather widely set up in various hospitals to determine beforehand the necessity for each therapeutic abortion.

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## Program of Therapy for Repeated Abortion Patients

By Carl T. Javert, M.D.  
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FROM the earliest times articles have been written on the treatment of habitual or repeated, spontaneous abortion patients, advocating various remedies. Virtually all of the methods that have been recommended yield a successful outcome in 80 to 90 per cent of these patients. Such phenomenal percentages have been reported by numerous physicians in various parts of the world and were obtained by such diverse therapeutic methods and agents, that it suggests a common denominator for all of the various methods, namely, *the great power of the placebo*.

Twenty-five years ago, empirical antiluetic therapy was in vogue for the treatment of repeated abortion. In fact, many of the older men still use it in this country and in Europe it is highly recommended. Cross, at the Rotunda Hospital in Dublin, recently reported 90 per cent success with injections of bismuth. Not too long ago Vogt-Moller of Copenhagen used vitamin E with 85 per cent success. Recently, Javert reported from New York and recommended psychotherapy and vitamins C, P and K to prevent decidual hemorrhage, with 87 per cent success. Smith and Smith of Boston have advocated increasing doses of diethylstilbestrol, with 74 per cent success. Vaux and Rakoff have used estrogen and progesterone in Philadelphia, and Karnaky employs a combination of stilbestrol and vitamins in Houston. The literature also refers to many other time-honored methods of treatment, including thyroid extract, bedrest, sexual abstinence, et cetera. The methods recommended by these investigators seem to reflect either their geographical location or the apparent needs of their constituents. For example, the dairy industry of Denmark stimulated interest in vitamin E, the author's use of psychotherapy reflects a proximity to Park Avenue, puritanical Boston and the City of Brotherly Love seem to favor the sex hormones, while Dublin still clings to antiluetic therapy.

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Read at the Michigan Clinical Institute in Detroit, March 10, 1955.

The author has had some experience with all of these various methods and does not wish to present a detailed discussion of any of them. Instead, he wishes to discuss a method of therapy which has been evolved over a period of eighteen years, a description of which was published last year in *Obstetrics and Gynecology*. Evolution of the method continues, as can be seen from a comparison of the program outlined below with the one published last year and with that recorded in 1949.<sup>6</sup> The most recent change has been the addition of calcium in early pregnancy instead of during the last half of gestation, for reasons discussed elsewhere.<sup>7</sup>

The program to be outlined below does not emphasize any one measure or agent above the other, and the end results obtained should be evaluated in terms of the entire method and not in terms of vitamins C, P and K. For example, those using hormone therapy tend to evaluate their results in terms of the hormones to the exclusion of other established principles of treatment, such as prenatal care, vitamin capsules and bedrest. It is probable that the high percentage of success obtained with various methods is due in part to a selection of patients for the therapy. Some workers have not followed the rigid criterion of Malpas, namely, three consecutive spontaneous abortions, but include those cases with three abortions that are not consecutive, i.e., a full term pregnancy after an abortion, which is then followed by two abortions. Others, especially those writing on the use of hormone therapy, have selected some of their cases on the basis of only two consecutive abortions or one abortion and one or two stillbirths. The reason for this is obvious: habitual abortion is a rare but vexing obstetrical condition.

### Definitions

Comparison of end results is often difficult because of selection of patients having been made according to different standards. The author has adhered to the rigid definition of habitual abortion, established by Malpas, namely, three consecutive abortions. He went further and divided

# REPEATED ABORTION PATIENTS—JAVERT

TABLE I

| Classification of Infant | Classification of Delivery | Birth Weight Grams       | Duration of Gestation in Weeks |
|--------------------------|----------------------------|--------------------------|--------------------------------|
| Abortus                  | Abortion                   | 0-500                    | 0-22                           |
| Immature Premature       | Premature                  | 501-1500<br>1501-2500    | 22-30<br>30-36                 |
| Full Term Postmature     | Term                       | 2501-4000<br>4000 & Over | 36-40<br>40 & Over             |

the cases into primary and secondary types, which has not been too practical. Other authors use only two abortions as their basis of selection, and at times these are not even consecutive.

A spontaneous abortion is defined as a pregnancy ending at or before the twenty-second week of gestation and resulting in a fetus weighing 500 grams or less.

"Primary habitual abortion" is used to classify patients who have had three or more consecutive spontaneous abortions beginning with the first pregnancy, i.e., primiparas.

"Secondary habitual abortion" designates those who have had three or more consecutive spontaneous abortions following delivery of one or more immature, premature or full term infants, i.e., multiparas.

A practical classification of infants, based on the fetal weight and the duration of gestation at the time of delivery, used by the Pediatric and Obstetrical Departments of the New York Hospital, is presented in Table I. It provides a statistical basis for tabulation of data showing the outcome of all pregnancies, *before* and *after* therapy.

Successful termination or outcome of a pregnancy is regarded as one that did not end in abortion but with the delivery of an immature, premature or full term infant, according to the above table of classification. The latter types make up the infantile mortality (exclusive of abortions). This removes the temptation to include stillbirths with the abortions when selecting the habitual abortion patient, as some investigators have done. All of us are in sympathy with her desires, as well as our own, when it comes to helping her but statistically, she should be omitted from any of the data on habitual abortion.

## Incidence

Habitual abortion patients are indeed rare, although spontaneous abortion is the commonest complication of pregnancy, having an incidence of 10 per cent. The pathologic causes have been

summarized by Hertig and his group in several publications. The author has also studied the pathologic aspects of 2,000 cases.<sup>7</sup> The incidence of primary habitual abortion has been reported<sup>8</sup> to be 1:300 of all the patients cared for at the New York Lying-In Hospital, while secondary habitual abortion had an incidence of 1:493. The author has just completed a pathologic study of 2,000 consecutive abortion specimens, and 104 (5.2 per cent) of the patients were habitual aborters, about equally divided between the primary and secondary types. It has been estimated that there will be 400,000 spontaneous abortions in this country in 1955, which is based on a total of 4,000,000 deliveries. Approximately 13,000 of the total number will be habitual abortion patients who will have 20,000 miscarriages in 1955. An estimated 100,000 physicians are practicing obstetrics, so that the average number of these patients cared for by any one doctor will be less than five. Even a busy obstetrician cares for only one or two of these patients per year.

The incidence of abortion in primary habitual abortion patients is 100 per cent. If 10 per cent is the usual abortion rate due to maternal or fetal pathology, then it is likely that the remaining 90 per cent of the abortions occurring in these patients is due to other causes. The psychosomatic factors can only be inferred, but experience has shown that they are very numerous and that psychologic abortions do occur.<sup>7</sup>

## Program of Therapy

"My office foundations were shaken,  
When treatment prescribed for the patient  
Was approved by her doc  
And took by the clock  
Without further ado from relations."

The program of therapy employed by the author has been designed to cope with the three main aspects of the spontaneous abortion syndrome—the antepartum bleeding, the uterine contractions, as illustrated in Figure 1, and the anxiety and concern manifested by the patient. The current program consists of four parts: Rapport, Dietary, Psychotherapy and Some Don'ts.

### Part I—Rapport

1. Preconceptional consultation (with husband). Questionnaire.
2. Examination and detection of specific medical, dental, gynecologic, mental and psychologic factors, defects and deficiencies.

## REPEATED ABORTION PATIENTS—JAVERT

3. Correction of all known factors, defects and deficiencies,—before conception.
4. Proper spacing of pregnancies.
5. Early prenatal care.

### Part II—Dietary

6. Adequate diet, high in citrus fruits: 350 mgs. of vitamin C daily.
7. High calcium and iron intake. Calcium lactate and iron supplements.
8. Vitamin C, P and K supplements. Ascorbic acid, 100 mg. three times daily, or Hesperidin C\*, 1 capsule two times daily each containing 100 mg. of hesperidin (vitamin P) and vitamin C. Vitamin K (Synkayvite\*\*), 5 mg. daily.
9. Thyroid extract, only when indicated by a minus basal metabolic rate.
10. Concern for weight loss rather than for excessive gain.

### Part III—Psychosomatic Therapy

11. Psychosomatic therapy:  
Frequent office visits  
Unlimited phone calls  
Group therapy  
Scrapbook of cases  
Constant encouragement  
Mutual faith
12. Sedation as needed: wine, beer, alcohol, phenobarbital. Other tranquilizing agents.
13. Dimethylane, 250 mg. three times daily, to produce relaxation of the uterus.

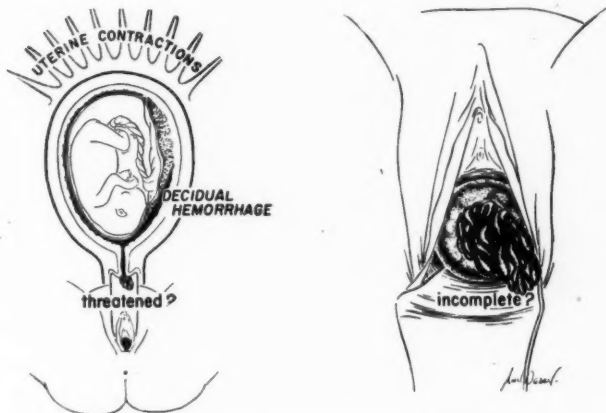
### Part IV—Some Don'ts

14. No hot tub baths, heating pads, hot water bottles or ice caps.
15. No complete bedrest (except for threatened abortion).
16. No sex hormones (diethylstilbesterol or progesterone).
17. No vitamin E.
18. No mineral oil.
19. No abdominal girdles.
20. No empirical antiluetic therapy.
21. No coitus during entire pregnancy.

### Control Data

Not infrequently, the author has been asked why he has not run a parallel or "control" series of cases, using the same program but substituting the placebos for the vitamins. This he has not done for several reasons: (1) habitual abortion patients are rare, (2) they deserve every bit as much therapeutic consideration as an arthritis patient, (3) a marked reduction in antepartum bleeding and decidual hemorrhage has been observed after using vitamins C and K, (4) these patients present themselves with the finest control data in the

world, i.e., outcome of pregnancies before treatment, for comparison with results obtained *after* treatment. It is like the mile runner who runs alone and reduces his racing time from 10 minutes



MECHANISM OF MINIATURE LABOR

Fig. 1. Mechanism of spontaneous abortion includes decidual hemorrhage, uterine contractions, and dilatation of the cervix, in effect, a miniature labor.

to 4 minutes after being trained and coached for this performance. Running the race against an opponent represents the usual method of obtaining control data.

### Results

The results of treatment on the pregnancy outcome of 100 primary and secondary habitual abortion patients have been published elsewhere,<sup>5</sup> and too few additional cases have been delivered to warrant another report at this time. Premature and full-term deliveries were obtained in 87 per cent of the patients.

The real measure of success is whether a patient takes home a living infant from the hospital, and 84 per cent did so, as shown by infant mortality data discussed below.

### Infant Mortality

Formerly, the total infant mortality of the New York Lying-In Hospital has been calculated on the basis of premature and full-term infants weighing 1500 grams or over (see Table I), who died in the first month of life. Infants weighing less than 1500 grams who died were classified as abortions, and those few who lived were placed in the premature group. Since 1950, the weight level has been lowered to 500 grams by Douglas, so that the premature now weighs between 500 and 2500 grams. The definition of abortion, immature, pre-

\*National Drug Company

\*\*Hoffmann-La Roche Company

mature and full term infants has been given above and in Table I.

The infant mortality rate was 3 per cent—one premature, one erythroblastosis, and one hydro-



Fig. 2. Psychotherapy. the psycho-somatologist at work.

cephalus. There were no fetal deaths in the infants delivered in the followup pregnancies.

### Congenital Anomalies

Many of the spontaneous abortion patients have been informed by their physicians that the embryo or fetus was defective and that the abortion was, therefore, a good thing. After this happens a few times the patient begins to wonder what the outcome will be, especially if she finds herself going to term. There were only two known anomalies in 100 treated patients; one a hydrocephalus and the other an abortus with a volvulus of the small intestine.

### Delivery of Repeated Pregnancies

Delivery of a habitual abortion patient of one normal, full-term infant is a special occasion. To care for her time and time again, using the same treatment, is even more gratifying. There are now twenty-two patients of the original group of 100 cases, who have been delivered more than once. Successful outcome was obtained in 85 per cent. Ironically, two patients were able to produce spontaneous abortions in five pregnancies by simply disregarding the various steps in the program. Both patients then resumed the treatment for five

additional successes. Three other successful patients have requested "therapeutic abortions," after several successful confinements. This procedure was performed on another patient for hypertensive disease.

### Two Consecutive Abortions

Many other investigators studying the problem of habitual abortions have used only two abortions as their criterion, and these were not necessarily consecutive. Wall and Hertig have studied the maternal and fetal pathology in a series of 100 cases with two or more abortions; eighteen had three or more. They concluded that the causes were similar to those observed in another study of 1,000 cases of spontaneous abortion. The author is about to publish a pathologic study of 104 cases (three or more) of habitual abortion in which he made similar observations.

A separate compilation was made of thirty-six cases with only two consecutive abortions, in keeping with this trend of considering patients with only two spontaneous abortions as "habitual aborters." There were twenty-six primiparas (two consecutive) and twenty multiparas (premature or full-term delivery followed by two consecutive). A few of these had up to five abortions, but since they were not consecutive they were not included in the statistics of the "true" habitual abortion cases, as defined above, but they were included in those having two consecutive abortions. These patients had been rendered no special consideration in the past and in deference to their pleas, "Why make me have three," they are now placed on the same program described above. The end results have been encouraging: the 79 per cent success was preceded by 80 per cent abortion.

### Psychotherapy

The type of psychotherapy used is of the home-made variety, familiar to any family doctor. What else is a doctor who delivers babies but a family doctor? It consists of the "laying on of hands" and relieving fears and anxieties, as in Figure 2. There is more to prenatal care than taking a blood pressure and doing a urinalysis. The sciences of somatology and psychology are employed in treating the patient as a complete individual. It is begun before gestation by a series of interviews designed to detect anxieties and personality disorders. The latter were found in 19 per cent of the patients studied by Berle and Javert and the anxieties

## REPEATED ABORTION PATIENTS—JAVERT

in all of them. Some patients need to be referred for psychiatric treatment. Further pregnancies may be contraindicated.

They provide a great proving ground for the study of the effects of psychotherapy as a medical form of treatment. No greater opportunity exists in the entire field of psychiatry for a statistical analysis of the end results obtained by psychotherapy than the habitual abortion patients that go ahead with another pregnancy. Our method emphasizes the principles of mutual faith and confidence, as shown in Figure 2. To achieve it is a painstaking, time-consuming effort that few doctors are in a position to adopt. They should learn to recognize an oversized dependency and exploit it in the doctor-patient contacts.

One patient, who had three consecutive abortions, consulted an outstanding doctor in a neighboring state. She was three months along and had been staining vaginally. She spent only five minutes in his office and left with a bottle of hormone pills and a pat on the back. She was in a panic over it when we saw her. Examination revealed a large cervical erosion that was bleeding. When reassured that it was from a nonobstetrical cause, she felt greatly relieved. She was placed on the author's program, the bleeding stopped, and she was delivered at term of a normal infant.

Recently the author referred a patient to a colleague in a nearby city. She had a history of three miscarriages and preferred a doctor nearby to care for her. (This is his view of what happened, not hers or mine.) After appraising the situation, he saw her at weekly office visits. Routine blood pressure, urinalysis, et cetera, were performed. Soon the patient volunteered the information that she didn't think that she would carry this one any better than the others. The doctor promptly told her he didn't think so either. A week or so later, she expressed the same view again. Later on, at

three and one-half months gestation, she voiced, again, the same disbelief. This time the doctor made a bet with her that she would lose it sooner or later! Several days later, she did abort. When the doctor told me of these events, he added, "You should know that I don't have time to fool with these characters." It was his way of telling me not to send anymore to him.

In conclusion, may I say to any physicians who contemplate, or are, caring for these patients, "If you don't have the time, don't fool with these patients."

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## ALMOST ALL BABIES NOW BORN IN HOSPITALS

Twenty-five years ago, when only about three out of ten Michigan babies were born in hospitals, sixty-three of every thousand died at birth. By last year, the infant mortality rate had fallen to twenty-five per thousand. The drop in the death rate for mothers at childbirth has been even greater—from one in every 165 births in

1930 down to only one in 2,000 today. It is significant that now 99 per cent of our babies are born in hospitals. Hospital care, made widely available by Blue Cross-pioneered prepayment plans, has been a major factor in making childbirth safer and easier for both mother and child.—*BC-BS Newsletter*, March, 1956.

# Simple or Nonspecific Ulceration of the Male Genitalia

By Noah E. Aronstam, M.D.  
Detroit, Michigan

**A**SIDE from the initial lesion of syphilis and the chancroidal ulcer, there are a number of simple or nonspecific erosions affecting the genitalia. These simple lesions are quite apparent and distinguishable to the observer and cause but little difficulty in diagnosis, if the past history of the patient and the symptom-complex be taken into consideration.

As a rule the initial lesion of syphilis has preceded it a more or less prolonged period of incubation; rarely, if ever, does the primary sclerosis appear earlier than the tenth day after coitus. If there still be a doubt, a dark field will conclusively determine the character of the lesion. The chancroidal ulcer as a rule has a brief period of incubation, seldom exceeding ten days.

The varieties of nonspecific ulcer may be classified as follows: the herpetic ulcer, the gonococcic erosion, erosions of the sebaceous follicles, the traumatic abrasion or erosion, and the diabetic ulcer.

In order to complete the above classification it may not be amiss to point out two forms which, though perhaps specific in their syndromes, could not well be included in the initial two mentioned at the outset of the article, and hence belong to the latter group, viz.: balanitis erosiva circinata and the less frequent but still recognizable tubercular ulcer.

The latter two forms will be briefly touched upon in the present article.

## Herpetic Ulcer

If the herpetic vesicles be unduly molested by various irritating or caustic applications, such as silver nitrate solutions, tincture of iodine, et cetera, they may rupture and become abraded. The same results, however, not infrequently occur spontaneously. Individual erosions may coalesce, giving rise to large sized ulcers. As a rule, however, herpes progenitalis manifests itself in groups, so that side by side with the ruptured vesicles we also encounter the presence of groups of herpetic

lesions intact in their primary formation, a fact that greatly facilitates diagnosis. Bearing in mind the above features, the diagnosis should not be very difficult.

The treatment consists in dry dressings or the application of simple, non-irritating dusting powders, such as plain talcum powder.

## Gonococcic Erosion

In the course of gonorrhea, especially so with an enlarged, elongated and constricted prepuce, the urethral discharge may erode the mucosa both of the glans and the prepuce. It is absolutely necessary to exclude the possibility of chancroidal invasion. But the history of the latter and its clinical appearance is entirely different from the former, so that mistakes are not apt to happen. Microscopically, of course, the gonococci are usually demonstrable in the former. In cases of mixed infection the Ducrey bacilli may co-exist and may be concomitantly discovered. The treatment should tend toward absolute cleanliness of the parts affected by deterging them with mild silver solutions, preferably of the viteline or peptonate group, such as solutions of Argyrol, and by giving penicillin intramuscularly.

## Erosions of the Sebaceous Follicles

The genitalia are profusely supplied with sebaceous glands. Like any other part of the body containing them in abundance, they are subject to various infections, commonly of a mild or simple nature. The staphylococcus group is chiefly responsible in their causation. It is frequently met with in those who work in oil or paraffin, or do not bathe frequently. Infection takes place within the sebaceous follicles which ultimately become obstructed by a plug of central necrosis, thus giving rise to minute focal abscesses. They commonly rupture spontaneously or by added friction of the underwear, leaving behind crateriform openings. If unduly irritated by caustic applications, there may at times appear a

marginal or peripheral induration which may be taken for the primary effect of syphilis. They are independent of sexual cohabitation and their clinical history, with a little study and observation, will eventually establish their exact character. The treatment is obvious, consisting of moist dressings of Burrows solution.

#### Traumatic Abrasion or Erosion

Friction from rough underwear will occasionally produce minute loss of substance on the genitalia; excessive moisture of the parts caused by intertrigo and profuse perspiration in hot weather may give rise to similar results. But such lesions are very insignificant and heal kindly by the application of an ordinary dusting powder, such as plain talcum or starch. These erosions are very superficial and the diagnosis readily suggests itself to the observer. Another form of traumatic erosion is occasionally observed after coitus. It is minute loss of substance, occasions no subjective disturbances, but may be the point of entry of various infective agents. If discovered early it should be disinfected either by a 5 per cent solution of Argyrol and a dry dressing applied.

#### Diabetic Ulcer

Glycosuria, which frequently modifies the processes of metabolism, acting upon the various structures of the body, also exerts its influence upon the cutaneous surface in giving rise to various erosions and abrasions. One of the localities not infrequently to become affected are the genitalia.

The diabetic ulcer as a rule is quite extensive. It may assume both a serpiginous and phagedenic appearance. Unlike the chancroid it never presents the worm-eaten, undermined character; in fact, it is a clean ulcer, the base of which is raw, beefy and non-pultaceous. Its margins manifest similar characteristics. Singularly it is unilocular. Very seldom do we notice two or more lesions.

Similar to the chancroidal ulcer, this type of lesion heals with great difficulty.

The diagnosis is established only by exclusion. It is needless to say that in all ulcers of doubtful character appearing on the genitalia two main features should never leave our mind: *urinary examination* and a *blood sugar test*. The general clinical symptom-complex of the individual may likewise offer an important clue to our inquiry.

The treatment of such types of ulcers is fraught with great difficulty. Local measures do not seem to materially benefit them, hence our efforts should be directed toward the general improvement of the patient by a strict dietary regime as an underlying basis. Injections of insulin systematically employed should be tried. The application of a 2 per cent solution of Castellani's dye has in some instances proved efficacious in mitigating the ulcer; a 2 to 5 per cent Argyrol solution may be tried. The high frequency spark has also been recommended in such cases as likely to be beneficial. Exposure of the ulcer to actino-therapy may be of value. Of late the various endocrines and corton have been administered with good results in some cases. We know so little, however, about internal secretions that their specific value in these cases is merely speculative. Of course we must give them a trial in this particular disturbance of metabolism in order to test their efficacy.

#### Balanitis Erosiva Circinata

Bataille, of France; Corbett and Harris, of America, and the author of this article, contributing to the *Urologic and Cutaneous Review*, have firmly established the pathologic specificity of this malady. The author is pleased to say that he has been diligent in investigating the characteristics of this affection, in studying its etiology and microbiology and in giving it its proper terminology, so that today this *fourth venereal disease* stands out as a distinct morbid entity.

This affection is comparatively rare. It affects the glans and mucosa of the prepuce and is characterized by the appearance of superficial erosions, distinctly outlined against a silhouette of healthy mucous membrane. They appear one-half to one cm. in circumference, bleed readily and emit an offensive odor and a copious secretion. There is a bilateral inguinal adenopathy. These lesions are due to a symbiosis of a spirillum and vibrio, which may be detected in smears taken from the preputial secretion. If not accompanied by gangrenous changes, they heal rapidly by promptly detarging them with solutions of potassium permanganate to 1:5000, and silver protinate 0.5 to 1 per cent. Later on, when healing has progressed and epithelization is established, simple dusting powders suffice. Good results have been obtained by exposing the lesion to the actinic rays.

### Tubercular Ulcer

This ulcer is a type sui generis; it is rarely encountered and the diagnosis is exceedingly difficult. Its usual sites are the glans and dorsal surfaces of the penis. *Phagedenism* is one of its main characteristics, while extension in continuity is very seldom observed. As has been remarked before, the ulcer is very deep, the margins indurated and plastic; varying amounts of pus exude from such an ulcer. Very frequently on repeated microscopic examinations the pus appears to be sterile when perhaps suddenly one may discover the tubercle bacilli. The presence of the latter is fugacious, indefinite and uncertain—a common characteristic of tubercular ulcers of other parts of the body. So called sterile pus should always arouse our suspicion as to the probability of tubercular involvement. Ulcers of this type are usually met with only during early youth, although one case came under my observation during well advanced middle age. We should always settle the question of diagnosis by serological test; a thorough inquiry into the past and family history of the patient is imperative. A Von Pirquet test is of no avail in such cases, as the reaction is invariably negative. A roentgenogram of the chest is imperative. Inoculating the

pus into the peritoneal cavity of a guinea pig and subsequent study of the animal is an important factor is determining the diagnosis.

The treatment of this form of ulceration is unfortunately problematical. Radio therapy in its various modalities, such as the x-ray and the Alpine light, have been used with indifferent results. In the case mentioned above in a middle-aged man, the ulcer seemed for a time to respond to a solution of hydrogen dioxide in glycerine, but its effects were not permanent. The case drifted into other channels, and thus the ultimate outcome remains unknown.

We must never for a moment forget the possibility of malignancy becoming supplanted upon chronic ulcers, especially so when occurring in advanced middle age. It is necessary to emphasize this so as to be constantly on our guard in prolonged and intractable lesions of this type, that may be but precancerous precursors.

In conclusion, the author desires to say that the data on this subject are very meagre in medical literature, and their occasional mention here and there is not ample enough to warrant any definite conclusions on the subject.

656 Maccabees Building

### HOWARD CUMMINGS, M.D., HONORED

(Continued from Page 772)

greatly expanded. Many hospitals of the State are now affiliated with the University in an extern, intern and residency training program which is recognized throughout the country as a forward looking step in graduate and postgraduate medical education.

In 1910, Dr. Cummings was married to Lou Braisted, who has been a devoted, loyal and capable helpmate throughout the years. They have two children. Robert is an outstanding surgeon in Phoenix, Arizona, and Mary Lou is a noted artist in the field of medical illustration.

It has been my pleasure to know Dr. Cummings for the past twenty years, and intimately as my chief for the past ten years. His high professional standards, his kindness and helpful disposition, his fine sense of humor, all have been a great inspiration to me.

Like many great men who are extremely busy, he still finds time to spend a few days each fall with his good friends at Camp Newton in the wonderful North country of the Upper Peninsula, and occasionally he throws a very good dry fly. His keen enjoyment of fishing is demonstrated, almost daily, during the summers at his cottage on the lake.

Dr. Cummings is held in high esteem by his colleagues at the University and St. Joseph's Mercy Hospital, the practicing physicians of the State, and thousands of loyal patients throughout the country. His kindly nature and sympathetic understanding, together with great professional ability, make him the beloved physician. Always modest and ever considerate of others, he has a host of friends wherever he goes. He has served his University and profession well, as demonstrated by the recognition which is being accorded the postgraduate medical education program at the University of Michigan, and by the tribute of this august body today.

We sincerely hope that we shall have the benefit of his counsel in clinical medicine in the fields of gynecology and in graduate and postgraduate medical education for many years to come.

Dr. Cummings, as a small token of appreciation for the many things you have done for others, it gives me great pleasure to present to you, on behalf of the Northern Tri-State Medical Association, the Distinguished Medical Citizenship Award.

# Directions of Psychiatry

By Francis J. Braceland, M.D.  
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I HAVE the temerity to discuss this subject, encompassed by such a sweeping general title, only because of the accident of being editor of an abstracting journal and also because you have elected me to several official positions which permit me to see the over-all picture of the directions of psychiatry.

Actually, no one can accurately foretell the directions of psychiatry. They are often governed by fortuitous circumstance. One change of direction of one aspect of the problem and the practitioners of the discipline are off in new directions.

Psychiatry, like all systems of thought, is influenced by the *zeitgeist*, or spirit of the times, and the age which nurtures it. This spirit is always etched into systems of ideas contemporaneous with it. The manifold features which make up the civilization of an age derive from the systems of ideas extant at the time. They are mutually interdependent. Even the physical sciences, which have changed the world and revolutionized our way of life, did not develop independent of the general spirit of the age which gave them birth and witnessed their amazing growth.

Some of the antecedent basic experiments upon which modern scientific theories and practices are founded are ages old; their implementation was delayed because the spirit of the age which contrived them did not demand experimental evidence. The general interest of these centuries was focused upon problems of a different nature. Parenthetically, it might be said that these times were concerned primarily with the problem of man, as modern civilization is puzzled by man as a problem.

I take this time to recount to you some of the cultural climate of nascent scientific thought merely to reinforce the idea that we are influenced by contemporary thought and the spirit of the times. We might go further and investigate the reasons for the preternatural delay in the appearance of a systematic body of medical psychology.

Presented at the Michigan State Medical Society annual session, Section on Nervous and Mental Diseases, September 29, 1955.

JULY, 1956

Its retardation becomes quite impressive when we appreciate the fact that fundamental knowledge of the neuroses and the possibilities of their influence by psychotherapy remained an enigma even though awareness of the role of emotions in bodily disease and dysfunction had been known for centuries.

In all other fields of science, including medicine and surgery, advances have depended not only upon the progress of general knowledge but also upon the development of an adequate technology. Endoscopy is a case in point. It could not have developed until technology had progressed far enough to perfect the requisite apparatus. Contrary to general medicine, however, medical psychology for the most part developed independently. It has been the span which has bridged the gap between the natural and the social sciences. It was, however, influenced by the times which gave it birth.

To pursue this train of thought further would lead us too far afield. I shall leave it after mentioning to you a warning uttered by Oliver Wendell Holmes in his address to the graduating class at Bellevue Hospital early in this century. He warned the medical profession that doctors, like everyone else, are inevitably carried along by the currents of the times and that it behooved them to recognize the laws which govern their changing practices. The debacle of a once proud, far advanced German medicine not so long ago serves as evidence that this warning requires attention. This is the background music for the thesis which I now present to you.

## General Picture

Psychiatry today occupies a unique position among medical and extra-medical disciplines. Integrated ever more closely with clinical medicine, it has provided new insights into large groups of medical problems. And because it seeks to clarify the dynamic properties of the personal and social environment and the types of processes observed between them, it has associated itself

with the social sciences and other disciplines concerned with human behavior. All of this bodes well for the progress of psychiatry. The complexity of our field dictates the wisdom of a multidisciplinary approach to the many problems that remain unsolved.

In view of the high incidence of mental illnesses and the heavy case loads borne by all of our mental hospitals, it might appear to the casual observer that we are centuries away from any real victory over these tragic and disabling afflictions. To them and to ourselves we must admit that a long hard road is still to be travelled. We must also add, however, that the progress made since the turn of the century, and especially in the last two decades, has been tremendous. Nearly two-thirds of today's first admissions to mental hospitals are discharged within a year. The annual national increment to the mental hospital population is about 10,000 patients, and this increment is largely explained by our growing population, their increased longevity, and the increased use of psychiatric facilities by the public and the medical profession. Hospitals are indeed overcrowded; but this is due for the most part to the backlog of chronic cases, many of them admitted before the advent of some of our most useful present-day psychiatric treatments.

Intensive treatment on all fronts has radically improved the recovery rates of first admissions for mental disorder, and has substantially improved the outlook for the more chronic conditions. As is true in the other branches of medicine, some of our most important therapeutic advances have come about through fortuitous discovery, and some from the fact that treatment based on faulty premises works for different reasons or in different diagnostic groups than the ones originally envisioned. (Meduna's work is an example.) For the most part, however, progress has come in the wake of arduous and unceasing clinical and experimental research.

We have learned from this research the role of the emotions in the human economy. We have achieved an understanding of man's capacity to gain knowledge of himself through dynamic procedures. We have substantiated, for mental health and mental illness, the importance of social relationships, communication and other interactions, particularly during the early years.

Research efforts in psychiatry are in broad spectrum, ranging from the pointing up of clinical

data to sharper focus, to complicated biochemical and other basic scientific procedures. The strategic position long held by medical psychology for the understanding and treatment of mental disorders has not been shaken, despite the discovery of various physical agents that produce excellent symptomatic effects in the major mental illnesses. The value of psychological methods is pointed up by advances in the principles and techniques of psychiatric diagnosis, psychiatric interviewing, and individual and group psychotherapy based on findings from psychodynamic research. From a multitude of studies it is clear that psychoanalytic formulations have widely expanded the potentialities of psychiatry. The insights provided by psychoanalysis have proved enormously fruitful in elucidating the forces which mould and maintain any type of psychopathology. And as psychiatry as a whole is moving in the direction of dynamically oriented psychotherapy, both in the individual and in the group situation, psychoanalysis, or at least a good representation of it, is now working toward the development of flexible analytic techniques which will speed up such treatment and make it possible to handle more of the patients who need it.

We are moving forward also in the area of chemotherapy. New drugs are in synthesis and others are being tested. Any evidence of clinical value always sends the chemists off in new directions which eventually lead to a more active therapeutic armamentarium. The introduction of chlorpromazine is typical of the progress under way. It is true that many drugs have created intense interest in the past, only to be found wanting with the passage of time. This may be the fate of chlorpromazine and of Rauwolfia, which is also much in the forefront at the present time. While great care must be exercised before making extravagant claims, it does appear as though both these agents are potent tranquilizers. When given in adequate doses, chlorpromazine seems beneficial in patients with increased psychomotor activity from almost any cause. In the experience of some workers, severe paranoid symptoms and hallucinations have sometimes been relieved, and it has even been suggested that chlorpromazine is the precursor of psychic chemotherapy of the future. Not infrequently, reserpine has a beneficial effect in patients mentally ill for a long time, changing them from unpredictable, resistive individuals to co-operative patients who can be

approached by psychotherapeutic and rehabilitative measures. These, then, are drugs which affect mood and improve behavior to such an extent that doctors are finding it possible to take a more dynamic approach to the underlying problems, an approach which the previous intractable condition of the patient had made impossible. One other thing: the appearance of these drugs has had a therapeutic effect upon many doctors themselves. Men working in hospitals with overwhelming case loads, heretofore impotent, now find themselves with drugs which are potent, and the effect upon their own morale has been salubrious.

Resurgence of interest in biochemical theory in relation to mental disease has been accelerated by work with the hallucinogens, particularly lysergic acid and mescaline. Depending on the dosage given, lysergic acid tends to produce schizophrenic pictures or disturbances of an affective nature. Mescaline, too, produces psychotic-like experiences and behavior, and it is evident that both mescaline and lysergic acid disorganize the psychic integration of the individual. The ability to produce an experimental psychosis in normal individuals may well cast new light on the nature of the functional psychoses, and much progress is to be expected in this area as time goes on.

Thus the advent of new drugs, the rise of chemotherapy, and, in collateral fashion, the awakening of neurologists and neurophysiologists to the challenge of mental illness—an awakening marked by research on many different fronts—all point new directions for psychiatry. The efforts in progress, particularly the exciting work on stress, may pave the way for discoveries of great etiological significance.

There are, in addition, pressures in and about mental hospitals which augur well for progress. It is becoming increasingly clear, not only to the psychiatric profession, but to enlightened people in general, that most existing psychiatric institutions are obsolete. Today we are woefully handicapped by the bleak, forbidding, dysfunctional structures built long ago to isolate the mentally ill from society. These relics of the past lend themselves poorly to modern psychiatric work. The mental hospital has been aptly called an historic accident. It reflects the mores of the past much more than those of the present. These institutions were built originally to get the mentally sick out of alms houses, garrets, cellars and jails. More often than not the devoted staff working in them is handi-

capped by the old dictum that they should be cared for as cheaply as possible. This policy in the long run is more expensive. It is a paradox of parsimony, and with their crowding the staff is kept busy with little time to attack the problem at its source. A sharp break with tradition is in order, and future mental hospital planning must be based on the fact that the art and science of healing can be carried out only in a therapeutic community where the march of patients toward regression can be arrested. This calls for a change in the external configurations, as well as in the internal atmosphere of the mental hospital. One cannot expect to cure a patient by removing him from one abnormal environment and placing him in another.

Since the advancing frontiers of psychiatry portend great changes in the treatment of patients in the future, all new hospitals should be designed for the greatest flexibility and for ready adaptation to new arrangements and functions. Therapeutic teamwork in mental hospitals is obviously of major importance. The conditions most conducive to recovery or improvement in patients are closely related to people working in the hospital and their attitudes toward patients, individually and as a group. Personnel attitudes which contribute to a therapeutic community do not arise spontaneously; they are produced by education, training and example, and by the co-ordinated functioning of medical staff with auxiliary personnel. Attainment of such objectives, it is scarcely necessary to point out, is contingent upon adequate budgets, well structured therapeutic programs based on the needs of the individual patients, and forward-looking administrative policies which will enhance the morale of workers and patients and foster an atmosphere of therapeutic optimism.

To be a therapeutic community, the mental hospital has to be patterned on everyday life. Further than this, it needs to be an integrated part of the community it serves and should, therefore, not be relegated to some remote spot passed only on occasion by the peripatetic masses. To its usual functions, namely the care and treatment of the mentally ill, should be added educational activities, not only in the training of many more psychiatrists, psychiatric nurses and auxiliary personnel, but also in the education of other physicians in psychiatric skills and insights, and in the education of the public in the field of mental health. The mental hospital should also

be a center of research in psychiatry and should take advantage of every opportunity to contribute to medical progress. (In military psychiatry—Navy, Army—are evidences of new ideas in disheartening situations.)

The improvement of mental hospital services, their extension into the community, the research and educational activities undertaken both inside and outside the mental hospital, should bring large rewards in public education, as well as further experience and data useful for preventive psychiatry.

### Prevention

Prevention of mental illness is an exceedingly complex task. It implies the control of causes. Yet in many important categories of psychiatric illness these causes are not clearly established. It seems more than probable that in almost any case of mental disorder more than one cause, indeed many more than one, is operative. Plural etiology by no means rules out the possibility of effective therapeutic work, and an attack upon one or another, or upon a combination, of the various etiological possibilities often gives spectacular relief to a severely ill patient. So, in prevention, we can work on some of the factors which we know tend to disturb the individual in his personal and social adjustment.

Sound programs of mental health can never be formulated if we spend all of our time in the diagnosis and treatment of processes already under way. Much depends on our ability to avert potential disturbances before they materialize. We must therefore have help from those who are in a position to detect the danger signs of incipient mental disorders. And of all those who are in a position to help, it is the general physician who can do the most.

Psychiatry is moving in many directions. The most rewarding, I have no doubt, will be that which integrates psychiatry with medicine and makes psychiatry an integrating influence in medicine itself. We have witnessed in the past few years the rapprochement of the psychiatrist and the general practitioner. There has been, as a result, more concerted effort to get cases of mental illness under treatment as early as possible. And psychiatry has done much to encourage the general practitioner to treat the minor manifestations of neurosis encountered in his daily practice, especially the mild anxieties and depressions that

are prone to masquerade as physical illnesses. Admittedly, the general physician is not yet altogether cordial to psychiatry but his feeling is much more receptive than it was. Strauss\* summarizes it nicely when he says:

"The modern psychiatrist presents a challenge and the attitude toward him is particularly ambivalent. At the same time as he is regarded with a considerable amount of suspicion and accordingly comes in for a fair amount of ill-natured banter, he is quite confidently expected to work therapeutic miracles and in double quick time."

Advances in the field of psychiatry are having a favorable impact throughout medicine. Future progress in the cure and prevention of disease necessarily depends on medicine that is comprehensive, medicine that integrates all the data of science into a continuous body of knowledge, and medicine that has its roots in the lives and needs of patients.

Medicine is finding it more and more difficult to keep integration abreast of specialization. The scientific advances which have brought epidemic and other devastating illnesses of the past under control have changed both the outlines and the details of clinical medicine. The proliferation of knowledge has brought with it increasing departmentalization, with loss of contact not only between departments but also within the whole broad field of medicine. At the same time, a lesser part of each doctor's treatment day is now devoted to the acute conditions that used to decimate the population; and the chronic, intermittently disabling disorders are consuming more and more treatment time. The role of emotional and environmental influences in these disorders is at last receiving some of the appreciation it deserves, as is the fact that the personality of the patient can be an important curative force.

And so, after years of preoccupation with pure science, medicine is moving toward a more unitary concept in which health and disease are viewed as related expressions or phases of life adjustment. This is a concept that dictates a return to the family type of medical practice, all but abandoned in the scientific harvest of the last half-century.

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\*Strauss, E. B.: Reason and unreason in psychological medicine (Croonian Lecture). *Lancet*, 2:49 (July 12) 1952.

## Visit to European Surgical Clinics

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IN SEARCH of information about the history of thoracic surgery in Europe, I set out in April, 1955, for a two months' trip. We flew to Prestwyck, Scotland, and then went by car to Edinburgh. Our stay in Scotland was to be very short. The first evening we had tea with Mr. and Mrs. Andrew Lang. He is in charge of thoracic surgery at the university and told me of the work they were doing. Being a young man, he could not, from first hand observation, tell me of the early work in thoracic surgery done in Edinburgh.

The next morning I attended the weekly conference of the staff of the Western General Hospital, the chief hospital connected with the university. On this morning the urological staff was in charge. After a discussion of the mortality from November 28, 1954, to April 23, 1955, an interesting paper on "Bladder Tumors" was presented by Mr. W. A. T. Robb, J. M. Drennan, and Prof. R. McWhirter. There had been 105 cases of bladder tumor on the service in the last five years, and 15 per cent had survived for three or more years. The final paper of the morning was on "The Closed Ileal Loop in Urology." In addition to the urological staff, Sir James Learmouth, the professor of surgery, was present. Many physicians in this country will remember that Sir James spent eight years at the Mayo Clinic, from 1924 to 1932, in the department of neurological surgery. After the meeting, Prof. Mercer took me to the home of the Royal College of Surgeons of Edinburgh. He is president this year, and they are celebrating their four hundredth anniversary. The main hall of the building was being redecorated, but I could see the portraits of many famous surgeons on the walls. He took me through the library and then left me with a biography of Sir William Macewen, the great surgeon of the 19th century, who did pioneer work in thoracic surgery.

From Scotland we flew to Oslo, and there I saw Dr. Carl Semb, professor of surgery in the University and an old friend of mine. He was in this country in 1937 when he demonstrated his

new technique for thoracoplasty with extrafascial apicolysis. He returned in 1949 for a shorter visit. He is well known to the thoracic surgeons throughout the world for his surgery of pulmonary tuberculosis. This year he is president of the Scandinavian Surgical Congress. Unfortunately for me he was not operating while I was in Oslo, but I did see one of his associates do a Semb apicolysis. I was most interested to see how radically it was done. Although Semb's predecessor, Holst, first carried out this operation, it was Semb who popularized it and made it known throughout the world. Semb still believes that thoracoplasty is more valuable than resection, although, of course, he does resections for certain cases. In this opinion he stood alone among the surgeons I met on my trip.

Although I have known of Semb mainly because of his work in thoracic surgery, he has continued to do general surgery and in the last few years has been interested in treating tuberculosis of the kidney by means of segmental resection, just as segmental pulmonary resections are done. In the series of eighty-seven cases he reported in 1953, the results were very good. Semb took me through the well-equipped laboratories, where he showed me work being done on studying the behavior of carbon dioxide under varying conditions. He is keenly interested in the work being done in these laboratories and gives up a definite part of his time to working there.

BCG has been in use in Norway since the early nineteen twenties, but since the war it has become compulsory for all school children and members of the armed forces. Semb believed that the definite decrease in tuberculosis morbidity and mortality has been due to its use.

From Oslo we flew to Stockholm. Dr. Clarence Crafoord, the professor of surgery in the university, was the man to see here, but unfortunately he had not returned from his trip to the United States, where I had recently seen him at a meeting. In his department of surgery at the Sabbatsberg Hospital, important contributions have been made to thoracic surgery, starting in

1935 with the manufacture of an apparatus to mechanically control respiration during anesthesia. Since then many other contributions have come, mainly dealing with the surgery of the heart and great vessels. His associate, Bjork, was also away, but Dr. Ake Senning, an able young surgeon, was in charge and kindly took care of me.

The Sabbatsberg sjukhus is an old hospital but is the chief hospital of the University of Stockholm. A new surgical building is soon to be started. The government recognizes the great value of the work done here and has been generous in its help. The operating room, in which I saw Dr. Senning operate, was a huge one, in which two operating tables may be in use at the same time. I saw Dr. Senning do a pneumonectomy while, on the other table, an abdominoperineal resection was being done. Across the back of this large room there ran a heavy wire, from which were suspended various wires, to be connected to other attachments to the patient on the operating table. Electrocardiograms and pressure readings during heart operations were obtained through these connections. The main wiring communicated with instruments in the adjacent room.

Then there were various floor connections for the anesthesia machines, so that the alternating pressure could be readily supplied. These machines are now controlled with alternating positive and negative pressure, and the whole set-up is very simple compared to the tremendous apparatus which covered an entire wall of the room in 1935. Dr. Friberg, trained under Dr. Waters in 1946, is in charge of anesthesia. He uses nitrous oxide-oxygen, curare, demerol anesthesia, and in most chest cases used the Carlens double lumen intratracheal tube. He is enthusiastic about it, and its use, in the pneumonectomy I saw, made me enthusiastic also. When the bronchus was cut, across no air escaped, and the operator could leisurely close the stump.

In 1951, Engstrom, of the Sabbatsberg staff, perfected a device which can take over the respiration of a patient completely. The unit operates by direct insufflation, but differs from other respirators in delivering a constant volume of air under different pressures. All the more common ones are either time- or pressure-cycled and deliver a certain pressure. A vacuum pressure, capable of being regulated, can be applied in the airways during the expiratory phase in order that the

mean mask pressure and the intrapleural pressure are kept on low values, so as not to impede the venous return and cardiac output during the insufflation breathing. This apparatus is connected with a tracheostomy tube by a cannula with a rubber cuff which fits in an absolutely airtight manner. I saw this apparatus in the operating room. It was beautifully housed in a cabinet which could be wheeled about with ease.

This device is used in the same instances in which we use the Drinker apparatus, which they consider to be entirely outmoded by theirs. They have been using it in all cases of bulbar paralysis from polio, in severely crushed chests, and in certain postoperative cases when the patient is having great trouble in spontaneous breathing. They are convinced that many lives have been saved by its use. In the other Scandinavian countries I found that they too had used this machine with great enthusiasm. In this country, in recent years, we have come to use tracheotomy more frequently, especially in bulbar paralysis from polio, but we have been slow to use it frequently in other conditions. The Swedes never hesitate to do tracheotomies and then connect their patients to this respirator.

BCG is used in Sweden as in Norway. There has been the same increase in incidence of cancer of the lung. Ninety per cent of the patients admitted to the surgical service of Crafoord are resectable. This is due to great care on the part of the referring physicians in screening the patients.

There are excellent experimental laboratories at Sabbatsberg, and I was shown the work that was being done on perfecting an extracorporeal heart. Much work of real value has come from this laboratory in recent years.

One day I went to Uppsala to see Prof. Gunnar Nystrom and the University of Uppsala Hospital. Prof. Nystrom, now retired from the University but still active in research, was in this country for six months with Blalock at Vanderbilt in 1930-1931. I had last seen him in Philadelphia in 1931, when he presented a paper before the American Surgical Association on pulmonary embolism. He operated on seventeen patients with this condition and two lived. Kirschner was the first to have success with the operation, and then Crafoord had two successful cases. Prof. Nystrom was the third person to operate successfully, and had the largest experience of all. This

subject of pulmonary embolectomy stirred the imagination of all surgeons at that time as had Cutler's first successful case of mitral valvulectomy, but since that time little attention has been given to it. The last successful case I know of was done by Valdoni of Rome in 1936.

The University of Uppsala Hospital was a fine modern one, which was the finest I saw in the Scandinavian countries. Arrangements had been made by Prof. Nystrom for me to see Prof. Olle Hulthen and to be shown through the hospital. When I reached the operating floor I was cordially greeted by several doctors. I understood that Prof. Hulthen was busy and that I could not see him until later. An attractive, younger, man took me in tow and showed me the fine new operating rooms, and the new amphitheatre. We then stopped for coffee with other members of the staff. I asked when I should be able to see Prof. Hulthen. To my great embarrassment, the "young man" who had just been escorting me around said that he was Prof. Hulthen. Dr. Paul Rudström, in charge of chest surgery, took me to his office, where I saw a fine picture of the Howard Gray family on his desk. Then Dr. Lars Thoren took me around to see the wards. They were all four-bed ones and very bright. In the corridors were mural paintings, and in the wards were framed pictures. This was true of all of the Scandinavian hospitals I saw. We left the hospital, and I was then shown the anatomy building, the amphitheater of which had been built in the 17th century as an exact model of the one in Padua where Vesalius had lectured.

At the University Hospital in Uppsala there are 200 surgical beds among a total of 900 beds. There are fourteen surgeons. Thirty-two medical students are assigned to the hospital. Medical students must spend from seven to eight years in school. They all have one year of military service. Those who wish to do surgery must spend from eight to ten years in training. Then they become chiefs of surgical services in county hospitals. The chiefs of the University Hospital are drawn from these men. Usually a man is at least fifty before he becomes eligible for the top positions. So Prof. Hulthen was not as young as he seemed to me. In the Uppsala Hospital no neurosurgery is done. These cases are all sent to Stockholm. They handle all other types of surgery. The general surgeons handle the fractures. No major surgery

is done in Uppsala, or in the surrounding country, except at the University Hospital.

We flew to Copenhagen on May 8. Here the University Hospital is the Rigshospital, and Erik Husfeldt is the professor of surgery. Last November I had the good fortune to meet him in Atlantic City at the congress of the American College of Surgeons, and to see him again in Philadelphia when he received honorary fellowship in the Philadelphia Academy of Surgery on the occasion of its seventy-fifth anniversary. He was most kind to me, and I spent two mornings with him at the Rigshospital. This hospital is an old one, and the operating rooms are large enough to allow two operations to be in progress at one time. On the first occasion, I saw him repair a hiatal hernia, and met some of his staff. On the second morning he put on a real surgical show.

The first case was that of a small infant with a ventricular septal defect. The child had been having fainting spells every day. Diagnosis had been established by cardiac catheterization. Hypothermia was induced, very esthetically, by covering the infant with plastic bags filled with ice cubes. The patient was on the operating table. An electric fan blew across the table, and the desired temperature of 28°C. was reached in thirty minutes. There had been no spilling of water and the patient was already in place on the operating table. Temperatures had been taken in the rectum, and in the esophagus, with electrodes connected with thermocouples. Dr. Ole Secher, the anesthetist, said that he considered the esophageal temperature to be the most exact. Prof. Frederick Therkelsen was the operator. He is in charge of the other surgical service at the Rigshospital. Dr. Husfeldt assisted. The heart was approached through a transverse incision across the sternum, and through the fourth inter-spaces. Control of the circulation through the vena cavae was established, the pericardium widely opened, procaine injected into the most prominent part of the atrioventricular region, and the heart opened. The defect was quickly closed with interrupted sutures of silk. Unfortunately, the heart failed to beat again.

After this operation Dr. Husfeldt repaired an atrial septal defect by his closed method of suture. The patient was a twenty-four-year-old farmer who had had increasing dyspnea on exertion. Before proceeding to the closure of the defect he carefully explored the heart through the

right auricular appendage. One's first reaction to this method of closure of a septal defect is incredulity that the closure should persist. Obviously, the encircling suture must cut through the tissue, but in doing so a reaction is set up in the tissue with resulting scar formation, and this ensures the permanent closure of the defect. Since the addition of the step of guiding the suture with a finger in the atrium, the results have been excellent.

Much was learned during an evening spent in the home of Dr. Tørning, one of the leading specialists in tuberculosis on the continent. We discussed the treatment of tuberculosis, and I was interested to find that he still uses artificial pneumothorax, and feels that the poor results others have had have been due to poor selection of cases and to poor technique. During the evening Dr. Johannes Gravesen, a pioneer in surgery for tuberculosis, joined us. He was the first man to use partial thoracoplasty, when the rest of the surgeons were still doing complete thoracoplasties regardless of the extent of the lesion. He has retired from his official positions but is still active otherwise.

Although this is a report on my visit to the surgical clinics of Europe, I think that it would be of interest to tell something about the wartime experiences of Dr. Semb and Dr. Husfeldt. The former carried on his surgical work during the German occupation of Norway until he learned that they were going to arrest him. With his family, wife and five children, he escaped to Sweden by rowboat. Once there he assumed medical charge of the large number of Norwegians who had fled to Sweden. After the liberation of Norway he became head of the health services for the country. Dr. Husfeldt did not continue his medical work but went underground. He became a leader of the Danish underground movement and near the end of the war was sent to San Francisco as a member of the Danish delegation to the meeting establishing the United Nations. For his part in the resistance movement he received many honors. When going through Elsinore palace I saw a huge new mural on the wall of one of the rooms. It was of a group of men in uniform, the leaders of the Resistance Movement. At the end was an excellent picture of Husfeldt.

Husfeldt's influence has been extended beyond the confines of Denmark. In 1950, he and Dr.

Valdoni of Rome were members of a team of doctors who went to India for six months. They gave lectures and operated almost every day. In Husfeldt's clinic I met a young Indian surgeon who had been working with him for two years. He was Dr. Chatterjee from Calcutta.

Our trip to Rome was a fascinating one as we flew to Zurich, and then from Zurich flew over the Alps in beautifully clear weather, and then on over the Ligurian and Tyrrhenian seas to Rome. Soon after our arrival at our hotel Dr. Valdoni, professor of surgery in Rome, appeared to bid us welcome. I had met Dr. Valdoni last March in Detroit at the international meeting on surgery of the heart. The next day I went to the Policlinic Hospital, which is the city hospital, and the University of Rome Hospital. It is similar in size to most of our large city hospitals, though somewhat older. But being the University Hospital, it differs from our city hospitals in having fine experimental laboratories, which were as well equipped as any in this country. And their animal laboratory has been in use since Malpighi's day.

Dr. Valdoni is professor of surgery in the University, and head of the surgical services at the Policlinic. He usually operates there every day from 10:30 to 3:30 or 4:00 and does an enormous amount of operating. He works in a large room with two tables. As he finishes at one table the operation on the patient on the other table is being started. When he finishes at one table he changes his gloves, and starts to work at once at the other table. In this way he wastes no time and thus can accomplish a great deal. He is accustomed to doing a lot of operating, as he told me that in one year in Florence, before he came to Rome in 1946, he did 500 gastrectomies.

I saw Dr. Valdoni do a pneumonectomy the first day. His technique was excellent. The patient received no blood during the procedure, but at its end his pulse and blood pressure were normal. He was to receive 500 cc. of blood on return to his ward. They were always ready to give blood in the operating room, but they have so much trouble getting donors that their bank is always poorly stocked. Blood, therefore, is only given when it is considered to be necessary. Following this operation he took me on a tour of the laboratories and x-ray department. The dog kennels were very commodious and in good condition, and elsewhere the equipment was superb. The Institute of Surgical Pathology I didn't visit

but apparently it is very active. Valdoni is also head of this.

The second day, I saw Dr. Valdoni do a mitral valvulotomy with successful finger fracture of the commissures. When he cannot fracture the commissures with his finger he uses the Dogliotti ring knife, an ingenious device in which the ring has been given a cutting edge. He has used this with complete success. Following the commissurotomy he did an esophagectomy for a long standing, and undilatable, stricture of the esophagus. There are still a large number of lye strictures of the esophagus seen in Rome. He anastomosed the stomach to the proximal end of the esophagus. In cancer cases he always does an esophagojejunostomy with a Roux Y loop, as he had found that he had too many cases of esophagitis following the use of the stomach. In the stricture cases he had had no trouble with esophagitis.

In the mornings between 8:30 and 10:30 he would usually operate in a nursing home on private patients. These homes are really small private hospitals, as they have house staffs and are fully equipped. Most Italians have medical insurance and go to the Policlinic for their surgery, but there are enough Italians who can afford private medical service and who take advantage of it.

One of the most interesting experiences of my entire trip was the visit with Dr. Raffaele Bastianelli. I had spent a day with him, and watched him operate in 1927. Now, at ninety-three, he was still active but no longer operating. He had only stopped operating last year because he felt that his eyesight was not good enough. And yet, when I was with him in his office and he wanted to show me some book on his shelf, he could see as well as I. He was studying a slide under his microscope when I came into his office. He was able to tell me much of the history of thoracic surgery in Italy and promised to send me a summary of what he could find out about it (the summary has arrived). He also told me that he had been the first person to remove a mediastinal dermoid cyst. This he had done in 1893 after resection of the manubrium of the sternum. Dr. Bastianelli had his office walls lined with bookcases, and there were many books of whose existence I was in ignorance. One on the history of surgery interested me very much, as I had not known of it. It was written by Dr. Leonardo, a former student of his who now lives

in this country. Dr. Bastianelli was surgeon to the royal household and came to this country to see Caruso in his fatal illness.

The Forlanini Institute, which is run by the National Institute of Social Security, is not a surgical clinic, but much surgery is done there. It was inaugurated in 1934 in honor of the Italian who first introduced the use of artificial pneumothorax in the treatment of tuberculosis. The present magnificent group of buildings houses 2,000 patients. The grounds are beautifully landscaped, and verandahs extend the length of the buildings. Each room with six beds opens on to the verandah, and there are curtains which are electrically controlled and can be raised and lowered by pressing a button. There are four floors and each one has its own dining rooms. A theater will seat almost a thousand, and moving pictures are shown at frequent intervals. The sexes are kept separate, and men and women are not allowed to attend the same performances in the theater.

I had a letter of introduction to Dr. Zorini, the head of the institute, but when I arrived he was busy and I could not see him. While waiting to see him, I was taken on a tour of the buildings by an official guide, who had learned to speak English while a prisoner of war of the English in Australia. The first rooms we saw housed the most beautiful anatomical and pathological museum I have ever seen. There were thin, translucent sections of the body in every plane, and they were standing free in the air in sealed glass jars. They have developed a process whereby the sections can be prepared and kept indefinitely in this manner. Not only were there sections of human bodies but also of various animals. It was indeed a most interesting experience.

I saw the fine modern operating rooms and the patients' rooms—where four of them shared a room—the huge kitchen and the main dining hall for ambulatory patients. The department which most interested me was one that had been established by Dr. Zorini and in which he was particularly interested. This was the rehabilitation unit through which every patient must pass before being discharged. Every patient within a year of being discharged is given aptitude tests. They are then assigned to work in the departments for which their tests have shown they have an aptitude. I saw large groups of patients learning typing, others were working in an

electrical shop, some were doing bookbinding, and a great many were sewing. All of these patients had the chance to equip themselves to earn a living on leaving the institute.

Finally I did see Dr. Zorini and had a most interesting talk with him. In Italy BCG has not been used, and yet there has been a definite decrease in their morbidity and mortality figures. In the institute both collapse measures, and resections are done by their staff surgeons.

Our next stop was Vienna, and I looked forward very eagerly to this visit, as I had spent a week there in 1927 and had had two interesting days at the Allgemeine Krankenhaus. Unfortunately, the timing of this visit was bad, as Prof. Wolfgang Denk, the emeritus chief of the Second Surgical Service, was leaving town for meetings elsewhere. He stayed over a short time, and I had a delightful hour with him in his office before he left. His office was the one used by Billroth, and on its walls were portraits of Billroth and of Denk. In the room also was the specimen of the segment of stomach which Billroth had removed in 1881. It was a pylorotomy for cancer, and the patient had died from liver metastases three months later. This was the first gastric resection to be successful.

Prof. Denk told me that he had been Von Eiselberg's assistant from 1908 to 1924 and had started his surgical practice in 1907. He was a pioneer in thoracic surgery. In 1911 he did a Délorne decortication for empyema, just as we do them today. In the same year he did his first thoracoplasty. In 1917 he did an extrapleural pneumolysis and in 1920 did a partial thoracoplasty. He has been especially interested in tuberculosis and in cancer of the lung. His ideas about the increasing incidence, and the relationship between it and cigarette smoking, are similar to the ideas of most of the surgeons in this country. A wonderful opportunity to study the effect of cigarette smoking on the incidence of cancer of the lung had been created by Hitler but could not be taken advantage of because of failure to keep statistics. When Hitler took over Austria, tobacco was a state monopoly. He, therefore, spread the word that anyone who smoked cigarettes was disloyal to him, and their use markedly decreased. With the end of the war cigarette smoking was resumed in the old pattern. Very valuable information might have been obtained had careful statistics been kept. In

regard to their cancer cases he said that only 20 to 25 per cent were resectable. The types of cases they receive on their service are comparable to those admitted to our city hospital services.

Prof. Denk's successor is Dr. Salzer, but he too was going with Prof. Denk to the medical meetings. However, Dr. Jenny, who is in charge of thoracic surgery, exclusive of the heart, was present and took me in charge after Prof. Denk left. The first surgical service of the University of Vienna is housed in the Allgemeine Krankenhaus, whereas the second, or Billroth, service is housed in buildings across the street. The buildings are old but in good repair. The operating rooms are huge, and the one used by Billroth is still in use. In it, two operating tables are usually in use. The wards are like the large old ones in our hospitals. I saw Dr. Jenny do a lobectomy with excellent technique, and I had an interesting talk with one of the anesthetists. She was Dr. Edith Simandl and had been trained in this country under Dr. Collins in Iowa, but had also spent some time under Dr. Waters and Dr. Beecher. In this clinic no ether was used for chest cases. The same combination of agents seen in use in the other clinics I had visited were used here. She felt very strongly that ether should never be used in chest cases. Unfortunately, Dr. Steinhardt, who is in charge of cardiac surgery, was not available, so I saw none of this work.

In Munich I had an interesting morning at the University Hospital. Dr. Emil Karl Frey is the professor of surgery and, as a former assistant of Sauerbruch's, has followed in his chief's footsteps. Sauerbruch spent important years in Munich, and a marble bust of him stands in the hallway near the operating room in which he used to operate. The hospital was badly damaged during the war, but the main operating room was not hit. The hospital has been rebuilt almost exactly as it was. The operating rooms I saw were huge ones, and in one I saw a pneumonectomy and a plastic operation being done, while in the next one, the professor was doing a cholecystectomy. Dr. Keutgen, the head of the thoracic surgical unit, took me on rounds. He has forty beds on his service and they are kept filled. The rooms I saw had two, and four beds in them. The beds had metal strips running overhead the length of the bed, from which were suspended stirrups which the patients could use to help them move about.

I had an interesting talk with Prof. Frey and Dr. Keutgen. They told me that about 95 per cent of the people had medical and surgical insurance, and that most of them took advantage of it. The rates were established many years ago and are fantastic in regard to certain operations. As the fee for thyroidectomy was set when nothing more than the removal of a small section of the gland was done, the fee for thyroidectomy is \$3.44, while that for appendectomy is \$7.14. It is obvious that no one could live on such fees, so fortunately there are enough private patients to make up the difference. As in all German, Austrian and Swiss university hospitals, the only member of the staff who can have private patients in the University Hospital is the professor of surgery.

Medical schools in Germany are open to all students who can qualify. They must have four years of elementary school and nine years in the gymnasium. This gives them an education comparable to our high school plus one year of college. In medical school they spend six years. During the first two and a half years they do no work in the hospital, except that they are allowed to serve as orderlies during their vacations. In the second two and a half years, they serve as clinical clerks in the hospital. They then have one year as interns, but in order to practice they must spend one more year in the hospital. To qualify as a surgeon they must spend one more year in medicine, and then five years in surgery. One of these five years may be spent in gynecology.

In Germany, as in Austria and Switzerland, no person will have an operation done except by a qualified surgeon. There is no law about this, but through the years the people have learned the importance of such a plan. There is no question of the patient going to some untrained physician because his fees would be less. If they can't afford the surgeon of their choice, they can be assured of the finest surgery in one of the city hospitals, as is true in this country.

My introduction to Swiss surgery was a most pleasant one. Thanks to Dr. Paul Holinger of Chicago, when we went to Davos, Dr. and Mrs. Hans Iselin met us at the hotel. He is a bronchoesophogologist who had his training under Dr. Holinger after the war. While he took me around to see the tuberculosis sanatoria, Mrs. Iselin entertained my wife. We went first to the sanatorium run by the Dutch government. Here there was a physiological laboratory under the direc-

tion of Dr. Scherrer of Vienna, where all of the patients in Davos who were to have chest operations had their pulmonary reserve studied. The laboratory has been in existence only two and a half years but has proven its worth. He studies their vital capacity first; then residual air is determined, arterial oxygen, and  $\text{CO}_2$ ; and finally bronchspirometry is done. Of 197 patients studied in this laboratory, 183 were found to have adequate reserve. Of the fourteen who were found to have inadequate respiratory reserve, but who were operated upon, eight died of cardiorespiratory failure. None of the others with adequate reserve had such an ending. After a tour of the laboratory Dr. Iselin showed me some bronchograms which he had made with water soluble Dionosyl. They were beautiful. He is enthusiastic about its value because of the ease with which the material can be moved about in the bronchi for some time after its introduction, so that under the fluoroscope the bronchi in which he is most interested can be selectively filled.

Davos was one of the first places in the world to have tuberculosis sanatoria, and people from all over the world have continued to come there. As the governments have taken over more of the control of tuberculosis, and people have been able to get free sanatorium care near home, the need for private sanatoria has markedly decreased. However, Davos is such a beautiful place, and so famous for its ski slopes, that it is still a mecca for ski enthusiasts as well as for people with tuberculosis. I saw the sanatorium made famous by Thomas Mann's book "The Magic Mountain." In those days the big sanatoria were more like large resort hotels, but today they are like the sanatoria elsewhere in the world. In 1934, Dr. Jessen, the leading thoracic surgeon of that time in Switzerland, was the guest speaker at the meeting of the American Association for Thoracic Surgery. He had been the model for the doctor in the "Magic Mountain," and I was most interested to meet him. He came over at about the same time as did Thomas Mann, and when I talked to him about the "Magic Mountain," he said that he thought more people in this country had read the book than in Europe.

That evening we had dinner with the Iselins and Dr. and Mrs. Felix Suter. Dr. Suter is the only surgeon in Davos who does major chest surgery, and he limits himself to surgery of the lungs and pleura. All other cases must be sent else-

where. He has a sanatorium of his own but does pulmonary surgery for all of the sanatoria. He still uses a lot of extrapleural pneumothorax and is enthusiastic about it. He continues to do thoracoplasties, but they are exceeded by the number of pulmonary resections. I was interested to hear him say that he gives PAS entirely by the intravenous route. He gives 24 gm. a day, and combines it with streptomycin, or with isoniazid. He gives 0.5 gm. of streptomycin a day for six-plus months before operation, and for two to three months afterwards.

After the visit to Davos I spent a pleasant morning in Lausanne with Dr. Naef, who had had his training in chest surgery under Overholt. I had met him in Boston and had just seen him at the meeting of the American Association for Thoracic Surgery in Atlantic City in April. He was operating in a small private hospital and did a difficult lobectomy with credit to his teacher. He was assisted in the operation by Dr. Carmine who had his training at the Massachusetts General Hospital. Naef is one of the pioneers in cardiac surgery in Switzerland, and is a member of the French society for thoracic surgeons.

In Basel I had a most interesting visit with Dr. Nissen, who has been professor of surgery there since 1950. I had known of him for most of my professional life, because of his own important contributions, but also because he was Sauerbruch's chief assistant for many years. He had left Hitler Germany in 1933 to become professor of surgery in Turkey. There he stayed until he came on a sabbatical leave to this country. He was in Boston when we entered the war, and as he had only a German passport, he was interned. He later went to New York, where he was able to practice surgery.

The Canton hospital, which is the University Hospital, is a large modern one with buildings forming three sides of a quadrangle, and with a beautiful lawn and garden in the center of the buildings. The first afternoon I had a chance to talk with Dr. Nissen in his office. He told me that the supposed autobiography of Sauerbruch's, which I had read, was not written by Sauerbruch but by a newspaper man. Sauerbruch had a stroke in 1950 and for the last two years of his life was entirely *non compos mentis*. Nissen felt that the book painted an erroneous picture of Sauerbruch. He felt that Sauerbruch was truly a great man. He said that Sauerbruch had remained anti-

Hitler throughout the war. Although Sauerbruch's reputation was high, and he was known to everyone interested in chest surgery in this country, he was not popular, as he had never been cordial to the Americans who came to his clinic after the first World War.

The next morning I went to the hospital to see Nissen operate. He had a most difficult pneumonectomy in a patient with an old tuberculous empyema and atelectatic lung. He showed his ability by getting into severe difficulty and then completing the operation perfectly. Following this, he took me into the large amphitheater where he was to give a clinic to the third-year medical students. He said that they liked to see foreign doctors. So, after he was received with applause, he introduced me, and I spoke, in English, for a short while. I told them how much we admired Swiss surgery, and how fortunate I thought they were to have such a distinguished doctor as their professor. The amphitheatre was interesting because there were large portraits of the great Swiss surgeons on the wall. He pointed out to me the portraits of Kocher, Courvoisier, and others.

From Dr. Nissen and Dr. Naef I learned something of medical education and surgical registration in Switzerland. Anyone who is qualified may enter a medical school in Switzerland. They must have the same qualifications as noted for Germany and Austria. They spend six years in school and then spend a year as interns before they can qualify to practice. To become a surgeon one must spend a number of years in training. They are certified as surgeons, as we do in this country. Their board of surgery is made up of four men chosen from the Association of Swiss Physicians. Two other men, appointed by the Congress of the Republic, upon the recommendation of the President, act as a board of appeals. If a man is turned down by the regular board, he may appeal his case to this board, but it rarely reverses the decision of the regular board. Among the Swiss medical societies are: the Association of Swiss Physicians, the Swiss Academy of Medical Scientists, Association of Medical Institutes, and the Société Swiss de Chirurgie. Any qualified surgeon must be elected to membership in this last society if he is proposed by two members.

In going to Paris I particularly wanted to see Dr. René Leriche, as he is one of the few men remaining who knew the great French surgeon

Tuffier. I wrote to him and was fortunate enough to find him in Paris. He has retired from active practice and spends much time on the Riviera. I went to see him in his office. To the maid who admitted me to the apartment I gave the letter that Dr. Leriche had written to me saying that he would like to see me. I was shown into a large polygonal room beautifully furnished, and with fine paintings and tapestries on the walls. There was a fine Gauguin, but I did not recognize the others. After some time Dr. Leriche appeared and took me into his office. Here again were many paintings but what struck my eye was a wonderful photograph of Dr. Harvey Cushing. It was an enlargement of a snapshot taken in Switzerland when Dr. Cushing was still in his prime. As Dr. Leriche would speak only French, our conversation was not entirely satisfactory. I did learn, however, that he considered the contributions of Roux Berger of Lyons to be the most important ones on the surgery of war wounds of the chest. They were published after the first World War. He had little to say of Tuffier, but later I was fortunate enough to have a talk with Dr. Marc Iselin, whose father had been associated with Tuffier during the first World War. He told me some interesting facts about his personality.

Thanks to Dr. Churchill and to Mr. Allison of Leeds, I had gotten in touch with Dr. Jean Mathey before going to Paris. He was very kind to me, and I had the pleasure of seeing him operate one morning. He operated in the Hospital des Malades Enfants with the most interesting operating room I saw anywhere in Europe. The operating table was illuminated by light reflected from the end wall of the room, against which a great beam of light was directed. The operation was repair of an atrial septal defect under hypothermia. The operation was beautifully done, but at the end the heart would not beat. At autopsy, it was seen that the pulmonary veins all emptied into the vena cava. Anesthesia for this operation was given by a woman who was one of the leading anesthesiologists in Paris. Most of these specialists in Paris are women. After this operation we went out to the Roses d'Hay tuberculosis sanatorium where Mathey does the surgery. All patients who are to have pulmonary resections have bronchograms and most also have bronchographic tomograms, to detect small defects that do not show up in the conventional bronchograms. I was much impressed with the bronchograms I saw. This

sanatorium is run by an insurance company, and all of the patients are policyholders. There was a resident staff, and the buildings and equipment were modern and in good condition. Mathey does the surgery, and said that they did about nine resections to every thoracoplasty. He took with him to the sanatorium the anesthetist who had given the anesthesia for the heart operation. She had been trained in England.

In discussing the problem of carcinoma of the lung with Mathey, he said that the same increase in incidence had been noted in Paris as elsewhere. He, however, has patients referred to him by men who are most careful in their studies. Last year he was able to do resections in forty consecutive cases, a record that I would not have believed could be possible. In general, he said that he was able to do resections in 90 per cent of the cases referred to him. I did not ask any of the other surgeons about their resectability rates.

The next day I went to see Dr. Dubost operate at the Hospital Marie Lannelongue, which is devoted entirely to thoracic surgery and is a city hospital. It was a modern building in every respect. Dubost was to do a repair of an atrial septal defect in a young man. He produced hypothermia by immersing him in a tub of ice water. I was not able to stay to see the procedure as it was the day I had an appointment with Dr. Leriche. He repaired the defect, but the heart continued to beat at a very rapid rate and the patient died some five hours after the operation. While I was waiting for the hypothermia to be produced, I had an interesting talk with one of the two physiologists attached to the hospital. He had spent two years in Minneapolis with Varco and Lillihei and goes back there again this year. He was Dr. Nanas, and I found that he was very much interested in medical education in France and had written an article on the subject for our *American Journal of Medical Education*.

At the Broussais Hospital the next day I saw Dr. Dubost do a mitral valvulotomy. The commissures could not be split with the finger. He used his little finger as his fingers are large, and he finds that the little one works best for him. Finding that his finger would not suffice, he introduced a dilator, similar to the Bailey aortic valve dilator, and quickly and easily split the commissures. He said that he had never had a failure with this method. At this hospital Prof. d'Allaine

is the chief of the service, and Dubost does all the cardiovascular surgery.

On my last afternoon in Paris Dr. Mathey took me, with a group of doctors, to meet Prof. Binet, the dean of the Faculty of Medicine of the University of Paris. We had a pleasant conversation and then we were sent through the medical museum. This was a most interesting experience. There were photographs, manuscripts and instruments dating back to the 16th century. Many of Ambrose Pare's instruments were on display. There was an anatomy, with a tremendous number of illustrations by Albrecht Durer. And then I saw an instrument, dating from the early eighteenth century, which had been used to keep lithotomy wounds open. It closely resembled the instrument I had seen Dubost use in dilating the mitral valve. The mechanisms for producing the dilating force were identically alike. From the museum we went to the library. It was larger than any library I had seen in this country, aside from the Library of Congress. The librarian, Mr. Hahn, was the third generation of his family to have held this important post. Before taking us on a tour of the place he showed us a book that had been kept by the deans of the medical faculty since its founding. On the first page was the date 1399, and then a page in longhand by the dean, recording the important events of the year. Except for the years of the Revolution this book had been kept up continuously. We then were taken on a tour of the library, which seemed very modern. I do not remember the huge number of people who used the library every day but it is obviously in great use.

My first morning in London was spent at the Brompton Hospital, where I watched Sir Russell Brock operate on a patient with both mitral and aortic stenosis. The auricular appendage was full of clots, and these were curetted out with a clamp across the base of the auricle. Before opening the auricle itself he occluded the carotids and pulmonary veins, then flushed out the auricle, and reapplied his clamp. He then inserted his finger through the appendage and explored the valve. He found that he could not split the commissures with his finger. He made a small incision in the left ventricle and inserted through it an aortic valve dilator like the one used in Paris by Dubost. Although he had his right index finger in the upper part of the valve, and thus could more accurately guide the instrument into the valve, he was

unable to split the commissures. Therefore he removed the instrument and closed the ventricular wound. Then he put a ring on his index finger and placed under it the end of a long handled knife. This knife resembled a tenotome. With it he was able to cut the commissures. Having succeeded in correcting the mitral stenosis, he proceeded to attack the aortic valve. This he did by incising the ventricle again and inserting through this wound the aortic valve dilator. He succeeded in appreciably enlarging the valve as was shown by the change in the pressure differential. Pressure readings were taken from the ventricle and the aorta. The needles were attached to plastic tubes which ran to a manometer on an adjacent table. The apparatus was so arranged that the tubing could be flushed at will with heparin and NSS.

The Brompton Hospital is one of the older ones in London and for a long time has been devoted exclusively to the care of chest cases. Many famous names in surgery have been connected with it. Two days after the operation just described, I saw Sir Russell operate again. This time he was operating on a patient with atrial septal defect, and doing it under hypothermia. I had heard him discuss his method for inducing hypothermia at the meeting in Detroit in March, and had been so much impressed with its value that I had asked him to demonstrate it for me when I came to London.

The patient was a twelve-year-old boy who had had a complete heart block for years but had little in the way of symptoms. First Brock explored the heart through the right atrial appendage, after having exposed it through a transverse incision across the sternum and into the fourth inter-spaces. The diagnosis of septal defect had been made by means of cardiac catheterization, and it was thought that he might have an anomalous arrangement of the pulmonary veins. No other abnormality was found, so cannulae were brought into the atrium through the appendage, and run into the vena cavae. The tubing connecting with the cannulae ran through a cooling apparatus. For forty-five minutes the blood was allowed to so circulate before the temperature fell to 28° C. The rate of cooling was carefully followed by Brock, who insisted on the temperatures being given to him every five minutes. The temperatures were taken from the rectum, from the pharynx and also from the chest wall. As the heart was

filled with cold blood, temperatures from the esophagus would be of no value. After the temperature had been at 28° C for ten minutes he started operating again. He feels that it is important to wait for awhile after the desired temperature has been reached before operating, so as to allow the temperature of the brain to fall to the level of the other places. He believes that the brain's temperature does not fall as fast as other parts of the body and thinks that one of his fatalities had been due to his operating too soon after the desired body temperature had been reached.

After removing the cannulae, he temporarily closed the wound in the appendage and then placed around the vena cavae and right pulmonary veins small rubber tubes. The aorta and pulmonary artery were isolated enough so that later a clamp could be readily placed across them. An incision was made in the auricle above a clamp, all great vessels were then occluded, the clamp removed and the atrial defect exposed. It was quickly closed with continuous suture, and the auricle clamped. The heart began to beat again with normal rhythm. The great vessels were then freed of their occluding clamps and tourniquets, and the blood flow re-established. The total time of occlusion was five and a half minutes. The order of removal of the occlusions was: first the superior vena cava, then the inferior vena cava, then the pulmonary veins, pulmonary artery, and finally the aorta. The wound in the auricle was closed, and then the cannulae reintroduced. Now the blood was allowed to flow through a warming system. This was continued until the temperature had risen to 35° and the cannulae were removed and the wound closed. At the end of the operation the patient was speaking and was in fine condition.

Between my visits to the Brompton Hospital, I went to St. Bartholomew's. There I saw Sir James Paterson Ross, the director of the surgical service, but he was doing no chest surgery that day, so I talked with him between operations. Sir James then arranged for me to see something of the hospital. He turned me over to Mr. C. H. Chamier, who apparently was an authority on the hospital. I had been so greatly impressed by the antiquity of the Dean's book which had been shown me in Paris that I did not expect to find anything equally old in England. Imagine then my surprise when I was told the story of the founding of St. Bartholomew's. A musician of the

King of England, Henry I, had gone on a pilgrimage to Rome. On the way he had fallen ill and expected to die. He made a pledge to God that should he recover he would erect a hospital for the sick poor in London. He then had a dream and St. Bartholomew appeared to him and said that he should build the hospital. In Rome he received the Pope's permission to build the hospital. Returning to London, he secured the permission of the King, who gave him land in Smithfield, where were the Royal market, and the execution grounds for criminals. Rahere was appointed the Pryor, and an order of Augustinian monks was established. The hospital was built after a church had been erected and was chartered in 1123. In the present chapel on the hospital grounds is a portion of the original church tower. When Henry VIII took over the church in England in 1536, he took over all of the church holdings, and St. Bartholomew's lost its charter. However, the citizens of London petitioned the King, and the charter was restored. It was the only hospital so chartered and is therefore the only one of the medieval institutions to have continued down to the present day. The only part of the original building is the church tower referred to above. Buildings have been added throughout the centuries, and since the last war a modern surgical building had been erected. It is now a truly modern institution and ranks high among the hospitals in England. Its medical school is a part of the University of London.

My last visit to a surgical clinic was to go to Leeds to see Mr. Phillip Allison. Although he is now Nuffield Professor of Surgery at Oxford, he is still at Leeds, awaiting the building of a hospital at Oxford. I had had the good fortune to meet him in Atlantic City last November at the meeting of the American College of Surgeons. He was made an Honorary Fellow of the College in Leeds in the preceding summer. Allison is particularly well known because of his writings on surgery of the esophagus, especially in regard to hiatal hernia, and to the use of the Roux Y loop for esophagojejunostomy after esophagectomy. More recently he has been obtaining pressures within the left auricle, pulmonary artery and aorta through the bronchoscope. When I saw him in June he had done two hundred such determinations without an unpleasant incident.

Leeds, an industrial city of more than half a million, is perhaps best known to surgeons in this

country because it was there that Lord Moynihan lived and worked. Even after he had achieved such great reputation he continued to live in Leeds, although he had a consulting office in Harley Street. He was director of surgery at the Royal Infirmary, and it was there that I saw Mr. Allison operate. He took me around the hospital a bit. It was large, and in fine condition, but I saw no modern building. In addition to the large public hospital there is a private wing, which I did not see. This must correspond to the Brooks House at the M.G.H. Mr. Allison has twenty-nine beds for thoracic surgical patients in the main hospital. He is allowed to keep all of the records of these patients and all of their x-rays in the office attached to this section. His secretary has charge of the records and x-rays. Elsewhere in the hospital the records all go to the central record room, and the x-rays to the x-ray department. The Royal Infirmary is the chief hospital for the University of Leeds.

I was particularly interested in his esophageal work and had asked him to arrange to do an esophagectomy for me. He had a patient with chronic esophagitis and an intractable stricture. Through an abdominothoracic incision he explored the chest and then proceeded to prepare his loop of jejunum. After this he freed the esophagus from a point just below the arch of the aorta down to the cardia. It was then resected and an anastomosis made between the proximal esophagus and the jejunal segment. This had been prepared as a Roux Y loop. Allison has been using the jejunum rather than the stomach after all esophagectomies for several years now, and he is convinced that it is a much better procedure. He has had no instances of esophagitis after using the jejunum, whereas before, when using the stomach, a certain percentage of the cases did develop esophagitis. Using this technique requires a much longer time, and the preparation of the jejunal loop requires the most meticulous technique. This patient had gastric mucosa extending

high into the esophagus, and it was ulceration of this tissue that had caused the trouble. Most writers and most surgeons speak of this condition as a short esophagus. Barrett, of London, some time ago showed that the condition commonly called short esophagus was really only an esophagus with gastric mucosa extending up its lumen for a variable distance. The gastric mucosa in this ectopic position is more vulnerable than in the stomach, and hence is the site of chronic inflammation. Allison has strongly supported Mr. Barrett in this contention.

Medical education in England is similar to that on the continent except that its medical schools are not open to all who are qualified. They select their students, as we do. The requirements for admission are similar to those on the continent, and to our own. After finishing medical school and their year of internship, they are qualified to practice. Those who wish to become internists take at least two more years of medical internship, then present a thesis, and if successful are given the degree of Doctor of Medicine. Men who wish to become surgeons do not take the years of medical internship, nor prepare a thesis, and do not receive the degree of Doctor of Medicine. Therefore the surgeons are not called doctors. It is true that the custom of calling surgeons Mister, instead of Doctor, goes back to the middle ages, and to the time when there were only barber surgeons. But even then several years of apprenticeship were required of the candidates before they were allowed to practice surgery. So, although the surgeons do not acquire the title of M.D., and are called Mister, they have always been required to prepare for many years before being allowed to practice surgery.

And so ended my medical excursions. I had seen the best surgery in each country I had visited. I had seen only the cream, and so am in no position to judge the quality of medical service, or of surgery, in the countries I visited. I had really only visited the university centers, and they were comparable to our best.

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If many tumors of a rare type or unusual site occur in a restricted population having in common some peculiar racial custom or environmental factor, the etiology may be deduced by statistical methods and verified experimentally.

Aminopterin (4-aminopteroylglutamic acid), the amino acid analogue of folic acid, is especially useful in treating children and young adults with acute leukemia. It is of little or no value in patients over thirty years old.

# Analysis of Anesthesia Problems

By Roy O. Webb, M.D.  
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THE problems of anesthesia are many and varied. Some are more or less limited to the field of anesthesiology. Some are common to other branches of medicine. Others are common to the various components of our worldly culture. It is within the scope of anesthesiology to cope with a few of these problems. Co-operation from other branches of medicine is necessary to correct some. Various fields of endeavor must co-operate to correct the others.

These problems may be classified as follows: (1) psychic, (2) technical, (3) ethical, (4) professional, (5) traditional, (6) economic.

1. Psychic problems refer mainly to fears, emotions, fanatical beliefs and superstitions on the part of patients.

2. Technical problems involve pre-anesthetic, anesthetic and post-anesthetic management of patients; care and use of equipment; and knowledge of agent and method.

3. Ethical problems involve conforming to legal statutes and practicing the art and science of anesthesia in accordance with the constitution and by-laws of state and national professional societies. These three categories could well be solved by the anesthesiologists if unhampered by influences outside their own sphere.

4. Through the ages most branches of medicine have endeavored to maintain an adequate and amiable patient-doctor relationship. The anesthesiologist, however, must maintain a satisfactory doctor-patient-doctor-hospital relationship. Failure of other branches of medicine to fully realize this difference of professional relationships often leads to problematical misunderstandings.

5. Traditions are a persistence of former practices and customs. In the evolution of anesthesiology from the discovery of chloroform in 1831 and the demonstration of the use of ether as an anesthetic agent in 1846, many changes have taken place. From the early use of these two agents as analgesics in home deliveries, the administration of anesthesia became known as a woman's job. Thus, in its later use in surgical procedures, its administration was delegated to nurses. Hospitals

then employed nurses as anesthetists and charged patients an individual fee for anesthesia.

Later, doctors became interested in the administration of anesthetics. This came about shortly after general surgery began to develop as a specialty. The referring physician, usually a general practitioner, administered the anesthetic and this custom prevailed for a number of years. Then, some few physicians became interested in developing anesthesia to a point where surgery could progress to operative fields heretofore inaccessible. With this development came the development of the surgical specialties, and anesthesiology was considered one of the surgical specialties. Anesthesiology has now developed into a specialty within itself. However, many hospitals are reluctant to give up their nurse anesthetists, and general surgery is apparently reluctant to relinquish its dominance of anesthesiology. This produces problems difficult to surmount, and from the standpoint of anesthesiology, the legal fraternity has little opportunity to prosecute violations of the "Corporate Practice Act."

6. Economic problems in anesthesiology are common to those of other branches of the medical profession and to practically all of the various components of our worldly culture. The high degree of specialization so far attained and demanded by all fields of endeavor and civilization, in general, has necessitated increased costs, which must be passed on to the consumer if present high standards are to be maintained and improved. Charles P. Emerson, Sr., M.D., a noted internist of some two to three decades ago, often made the statement, "The practice of medicine in any given era conforms to the culture of that particular period." To me, this is a very noteworthy statement and should be widely publicized. If anything is wrong with the present practice of medicine, then, the same fault exists with the culture of the present time.

The panorama of our worldly culture, in the past two decades, seems to have changed from an atmosphere of dubious tranquility to one of

irresponsible high pressure. Expressions from laymen from different walks of life indicate that it is desirable for the practice of medicine to retain its serene tranquility. They do not seem to realize that the practice of medicine must go along with the culture of the times if it is to exist and maintain its high standards.

It is my humble opinion that every field of endeavor is dependent, to a greater or lesser degree, upon every other field of endeavor. In the field of medicine as a whole, each recipient of medical service and care is a separate and distinct case unto itself. There is a vast difference between custom-built Cadillacs and line-run Fords, yet both are automobiles and each capable of transporting people and merchandise. Likewise, there is a vast difference in cost. There is also a vast difference between anesthesia for incision and drainage of an abscess and anesthesia for excision of a coarctation of the aorta, yet they are both anesthetics. Here, too, there is a difference in cost. When each commodity and service does not

receive adequate compensation, an economic problem is initiated.

The problems of the six categories listed above result in one major problem, "Exploitation of Time." All components of our worldly culture, therefore, should co-operate to eliminate this exploitation of time. Each individual is responsible for compensating for any commodity or service he receives. Mentally and physically defective individuals and life's unfortunates should be aided but not unduly at the expense of our group or one individual. Duty should not be influenced by sentiment. Economic stability should not be sacrificed to appease unjust demands by pressure groups.

Facts speak for themselves. Anesthesiology is a distinct branch of the medical profession. It must be considered and respected as such. Anesthesiology, united with all the branches of medicine, must insist on adequate compensation for services rendered. Concentrated efforts should be made to reduce to a minimum the exploitation of time.

## THERAPEUTIC ABORTION

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# Thorazine in the Treatment of Acutely Disturbed Psychotic Patients

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THERE are presently well over thirty papers in the literature on the use of Thorazine in the treatment of various medical, surgical and psychiatric conditions. Chemically, the drug is related to the antihistamines, but its actions differ from antihistamine type drugs in a number of regards. Primarily, it is a central nervous system depressant and, secondarily, has a mild antispasmodic and adrenalytic activity. It potentiates hypnotics, sedatives, narcotics, anesthetics and alcohol. It appears to act at the cortical and subcortical levels in the cerebrum and on the diencephalon. Its sedative effect is thought to be the result of interruption of impulses passing between the diencephalon and the cerebral cortex. Animal studies indicate that some degree of tolerance to the drug develops, and our clinical impression in the use of Thorazine with patients supports this. It has a wide margin of safety for clinical use, although it has been reported that an obstructive type jaundice develops in 1 to 2 per cent of patients receiving it over a prolonged period of time.

D. Elks, writing in the *British Medical Journal* of September 4, 1954, studied the effects of Thorazine on chronically overactive psychotic patients. He used only 150 milligrams a day, except in a few patients who received 300 milligrams a day transitorially. Of his twenty-seven patients, nine showed an increase in weight from 11 to 34 pounds in twenty-two weeks. Seven of the patients were considered definitely improved, and eleven slightly improved. Improvement did not become apparent until after three to six weeks of continuous medication. The affective group appeared to respond slightly better than the schizophrenics. Patients became quieter, less tense, and less disturbed by their hallucinations and delusions, and more amenable to the suggestions and care of the nursing staff. Three patients of the twenty-seven were thought fit for parole, though none was considered fit for discharge.

In none of the cases was the content of the psychosis changed. Schizophrenic patients continued to be subject to delusions and hallucinations, the affective swings of the hypomanic patients continued at intervals normal to each patient, and the chronically agitated melancholics did not themselves admit to any improvement in their mental state. He felt that the relief afforded by the chlorpromazine thus was principally symptomatic.

Garmany, May, and Folkson, writing in the Department of Psychiatry, Westminster Hospital, described the use and action of chlorpromazine in psychoneuroses. They had eighteen cases where tension was predominant and improvement occurred with medication. Results in patients with predominant obsessional symptomatology were poor. They could not confirm the findings of Sigwald and Bouttier concerning the relief given by chlorpromazine to patients with obsessional, depressive, or phobic symptoms. They did concur on the value of the drug in alleviating tension, both in its affective and muscular sense. They suggested that a combination of chlorpromazine, psychotherapy, and what they speak of as "relaxation treatment" appears to give the best results obtainable in the treatment of the tension state. Lancaster combined chlorpromazine and insulin in the treatment of eleven patients. They concluded that the drug caused apparent, but not significant, decrease in the total number of insulin induced anxiety symptoms, and altered the type of these symptoms. Palpitation and tachycardia were increased; perspiration, flushing, anxiety, restlessness, epigastric sensation, and tremor were diminished. Chlorpromazine did not influence the action of insulin on blood sugar levels. A combination of insulin and chlorpromazine was found to be useful in controlling refractory excited patients who were not controlled by either drug alone when administered in dosages of 50 milligrams three times a day. They felt the combination was useful in making more manageable pa-

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JULY, 1956

tients who become excited during insulin coma treatment.

We should like to report here our experience with the use of Thorazine in varying dosages in thirty chronically disturbed psychotic patients. When the project was initiated, it was decided to administer the drug to patients who were disturbed, and who, because of this fact, were management problems on the ward. Initially, the dosages were rather low, being approximately 75 milligrams per day, but with the rapid gains in experience with the drug, our staff members began rapidly stepping up the drug dosage so that one patient received 500 milligrams per day, the bulk of them receiving between 100 and 200 milligrams per day. The drug is prepared for both intramuscular injection and as tablets. Many of the patients would take the drug by mouth, but in those instances when they would not, the drug was given by injection intramuscularly and the almost universal experience with these thirty patients was that after a few days, the patients would willingly take tablets and injection was no longer necessary. The drug was not given on the basis of diagnosis, but rather on the basis of clinical evidence of marked intrapsychic disturbance. It soon became apparent that low dosages were essentially ineffective in the management of patients who were markedly disturbed, and it was necessary to administer larger amounts. A rule of thumb was that a dose was sufficient to cause the desired result.

When the dosage was sufficient, there was usually improvement in the patient's personal appearance within a short period of time; in general, one week after effective dosage levels had been achieved. Where many had been untidy and incontinent and unkempt, they began to dress more neatly and show more attention to their personal appearance. Somewhat more striking was the change in their behavior. Patients who had been assaultive, destructive, and combative showed improvement in their behavior, becoming much quieter or only showing agitation. In general, the trend of the drug effect was to quiet the hyperactivity which was common to the majority of this series. So far as the patients' activities were concerned, the Thorazine seemed to have a desirable tranquilizing effect. It was found in those instances where patients could be helped to overcome their initial disturbance, and could be gotten to occupational or recreational therapy or work

therapy, that they could continue the new activity even when the Thorazine was discontinued. It was likewise found that patients given Thorazine alone without any additional therapeutic measures frequently relapsed to their previous disturbed condition when the Thorazine was discontinued. It was as though Thorazine acted as a therapeutic lever enabling the physician to shift the patient into a more productive, more healthy activity. We found very little change in the mental trends of patients receiving the drug. They continued as previously, although they did not have the active force behind them that was noted before Thorazine was given. Paranoid delusions continued unabated, but tended to be less spontaneous and elicitable only on questioning. Two patients with obsessive-compulsive symptoms showed no change in this behavior. We found that there was some change in the affective area, with patients becoming less hostile, inappropriate or depressed when under the influence of Thorazine. It should be understood that this is quantitative rather than qualitative and that the essential psychopathological process was not in any way altered by the administration of the drug.

A certain amount of tolerance seemed to develop to the drug. For example, one patient who was gradually built up to a dosage level of 400 milligrams a day had the drug discontinued because the supply ran short. When the drug became available again in a few days, she was placed at the same dosage level and showed marked side effects with drowsiness and sleepiness. This seems to indicate that some tolerance develops as long as the patient is on the drug, but disappears in a short time. The small dosage level in the tablets made administration somewhat difficult, and taking the medication was referred to jokingly as, "It was like eating a handful of popcorn." A 100 milligram tablet is currently available which makes administration simpler.

The over-all impression of the effect of Thorazine on this group of thirty disturbed psychotic patients is as follows: no patients became worse, eight patients showed no improvement, seven patients showed slight improvement, eleven patients moderate improvement, and four patients marked improvement.

Side effects were noted in eight patients (somewhat less than one-third the total) a figure somewhat higher than that recorded in the literature. Five of the patients complained of drowsiness, with

three of this group of five complaining of the additional symptoms of dizziness. These reactions did not seem to correspond with the dosage level which ranged in these particular individuals from 50 milligrams a day to 500 milligrams a day.

Of the remaining three who had side effects, these were somewhat more serious. One, at a dosage level of 200 milligrams a day, showed marked facial puffiness and a mild generalized macular rash with pruritus. This disappeared within seventy-two hours after the drug was discontinued. The second of these three patients initially showed nausea, vomiting, and syncope, and at the maximal level of 400 milligrams a day, experienced a pruritic, macular rash on the face and back and a slight generalized facial edema. This toxic effect disappeared within twenty-four hours after withdrawal of the drug. The third patient of these three experienced an intercurrent temperature elevation and complained of pain in the substernal notch. She was on a dosage level of 200 milligrams a day. In summarizing the side effects, then, approximately one-third of all patients had side effects and 10 per cent of all patients had side effects of serious to moderately serious degree. One patient, not included in this series, was given Thorazine in withdrawing her from dilaudid addiction. At a dosage level of 300 milligrams a day, the patient showed no withdrawal symptoms, and the drug apparently modified or prevented nausea and vomiting which is common with withdrawal and allayed her anxiety. There was some dizziness which she experienced

and difficulty in focusing her eyes, a symptom not complained of by any other patient.

There seems to be little question but that Thorazine has a place in the armamentarium of the psychiatrist. However, it is not a magical drug which can be dispensed with the idea that the drug itself will cure the patient or insure his improvement. When combined with other measures, however, it seems to have real promise. In a number of patients, particularly the ones who showed marked improvement, the patients were able to engage in work at the hospital, go to occupational therapy, or take part in other activities which previously had been impossible for them because of their disturbed state. When the Thorazine was withdrawn, those patients who had made movement and progress in other areas remained improved, whereas those who had not moved in other therapeutic areas for the most part relapsed. Dosage level was very important in achieving good results. Our highest dosage level was 600 milligrams per day, but for the most part, patients benefited by approximately 300 milligrams per day.

From our rather limited experience with the drug, and from a review of the literature on its use, it would seem that Thorazine has a tranquilizing effect without altering the basic structure of the psychosis. It provides a valuable tool for the psychiatrist in assisting the disturbed psychotic patient to engage in more productive and healthful activity.

## ENDOMETRIOSIS

(Continued from Page 794)

patients having sterility and endometriosis will become pregnant with the employment of testosterone therapy, and about 55 per cent will become pregnant following conservative surgery.

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# Detroit Surgical Association

Meeting of April 23, 1956

## CAROTID ARTERY OCCLUSIONS: DIAGNOSIS AND TREATMENT

By JOHN E. WEBSTER, F. A. MARTIN and  
E. S. GURDJIAN

The material pertains to a presentation of evidence supporting the presence of collateral circulation in the brain as revealed by (A) angiographic studies, (B) studies of thepial circulation in the brain of the monkey, and (C) the ability of cerebral vessels to dilate as shown by cinephotomicrography. The clinical effects from digital carotid compression in humans are presented to support a conclusion that such compression may have therapeutic value in encouraging collateral circulation in patients having cerebrovascular insufficiency due to partial or complete carotid occlusions.

## ACHALASIA OF THE ESOPHAGUS

By W. M. TUTTLE, and R. J. BARRETT

Cardiospasm, or achalasia of the esophagus, is most likely due to a neuro-muscular imbalance at the cardia. There is considerable histologic evidence of degeneration of Auerbach's plexus ganglion in this condition. Previous attempts at surgical repair of this condition have utilized:

1. Dilatation. Either through the esophagus by instruments or digitally through an incision in the gastric wall.
2. Plication of the dilated esophagus above the area of constriction—a totally senseless procedure.
3. Excision of the constricted area, either locally or on with a portion of the stomach.
4. Deviation of the flow around the area by anastomosis of the fundus to a point higher in the esophagus.
5. Plastic procedures on the cardia of which the Wendell operation consisted of a longitudinal incision through all layers of the esophagus and through the constricted area and on to the cardiac portion of the stomach. This was then closed in a transverse fashion. The Heller operation consisted of a longitudinal incision through the muscularis down to but not through the mucosa and was made both anteriorly and posteriorly. This operation was followed by the least number of complications and was, in general, successful but had a fair recurrence rate. Most of the other procedures in which the mucosa was opened and sutured had a fairly high rate of anastomotic ulcer following it. We have had our best success in twenty cases treated by a modified Heller operation, in which a longitudinal incision is made down to but not through the mucosa, following which the muscularis is closed in a transverse fashion. Apparently, the mucosa fold so formed acts as a valve preventing reflux. In eighteen of the twenty patients, results were very satisfactory.

## THE RESPONSE OF EXPERIMENTALLY PRODUCED ACUTE HEMORRHAGIC PANCREATITIS TO CORTISONE

By POWELL PERKINS and C. JACKSON FRANCE

An investigation of the effects of cortisone therapy on the survival time of dogs in whom acute hemorrhagic pancreatitis was created experimentally was done using both intramuscular and intravenous cortisone. Two series of animals were studied.

In the first group pancreatitis was created in 20 dogs by devascularizing the distal one-half of the anterior lobe of the pancreas, ligating the main pancreatic duct, and infiltrating the anterior lobe with formalin (1 cc. per 10 pounds body weight). Ten animals were given I. M. cortisone 1 mgm/lb. daily for five days. Eighty per cent of these treated animals survived as compared to only 20 per cent of the untreated dogs.

In the second series pancreatitis was created by ligating the ducts of both lobes of the pancreas, ligating the superior pancreaticoduodenal artery and infiltrating the entire gland with 10 per cent formalin. Alternate dogs were given hydrocortisone 1 mgm/lb. intravenously in 5 per cent D/W for five days, and the remaining were given an equal volume of cholesterol solution. In this group 70 per cent of the treated animals survived and in the untreated only 30 per cent survived.

Postmortem examination of all dogs revealed extensive hemorrhage and necroses of the pancreas and also enzymatic digestion of the pancreatic cells and blood vessels. Serum amylase values ran as high as 6000 u.

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The events in early life may be important in determining the presence of tumor later during the typical carcinoma age.

\* \* \*

The induction period for tumors may be long and a tumor may occur long after exposure to the etiological factor has stopped.

\* \* \*

The more the racial peculiarities of cancer are studied, the greater is the tendency for them to indicate environmental rather than truly hereditary causes.

\* \* \*

The technique of studying large populations by statistical methods, geographically and racially and before and after mass migration, appears to be a very promising method for revealing etiological factors.

## Education in the Art of Medicine

Is it possible that instruction in the Science of Medicine is too far ahead of that in the Art of Medicine? Many of us continue to ponder this question, and after talking with a large number of young men who were graduated recently from medical school, I am even more impressed that something of the philosophy of the private practice of medicine is lacking from modern medical education.

Our medical schools are doing an excellent job of teaching scientific medicine, but it appears that their scientific programs are so crowded there is little time left for instruction in the social and economic side of medicine.

This is regrettable because as our scientific knowledge expands and as physicians care for more and more patients, it would seem increasingly important that new doctors have a prior knowledge of the Art of Medicine, the pitfalls of practice, ethical principles and medical socio-economics.

It is true that many county medical societies now have excellent programs of indoctrination for new members, as well as "refresher courses" in socio-economics for older members. Such indoctrination programs are very commendable, and these activities should be enlarged. However, it would seem much more effective if these men had been reached long before they were eligible for county society membership.

In recent years MSMS has sponsored a conference for interns, residents and senior medical students at the time of the Michigan Clinical Institute to help these young people get a clearer picture of actual day-to-day practice of medicine from doctors already serving the people of Michigan as private practitioners. Those attending these conferences get a different view of the physician's problems and responsibilities than they do in the halls of the universities. This is a good start.

Under the able chairmanship of R. W. Teed, M.D., of Ann Arbor, MSMS also has made progress in presenting socio-economic topics through special lectures presented at the state's two medical schools periodically. This, too, is a fine start toward teaching the Art of Medicine even before the years of internship . . . when it is most effective.

My hope is that in the future, MSMS will be able to make even greater strides in preparing future doctors for the private practice of medicine as a regular part of undergraduate medical education. I sincerely believe this is one of the most important phases of learning how to be a true physician.



*President, Michigan State Medical Society*

*President's*



*Message*

# Editorial

## NEW MEDICAL CENTER

In Detroit, on May 23, 1956, announcement was made of plans for a new medical center, using Harper Hospital, Grace Hospital, Woman's Hospital and Children's Hospital plants now in operation. The surroundings of some of these hospitals are slum areas. It is proposed to acquire about eighty-five square blocks surrounding these hospitals, extending from Woodward to Hastings, the new Expressway, and from the Edsel Ford Expressway to Mack. About six of these eighty-five blocks will be occupied by Harper, Grace, and Woman's Hospitals and their auxiliary services. An extension is to include Children's Hospital which is some distance removed. The whole area contains about 200 acres and includes many worthwhile structures which are to help make the center more useful and attractive. Included are the Institute of Arts, the Rackham Building, the Cancer Research Institute, several churches—some of which are large, four schools—some private, many good business establishments, good apartments and hotels making up islands in this over-all slum area.

On the sites vacated will be built numerous apartments and other structures to house the 3,600 employes of the four hospitals. Parkways and parking facilities will be used to beautify the area and businesses which might be somewhat kindred to a medical center will be invited to locate here. It is estimated that to acquire the necessary land will cost \$22,000,000. The first announcement placed the whole project as over \$100,000,000 but it will be several times that amount.

### Convalescent Care

What a wonderful opportunity actually to attempt a scheme which has challenged many medical and hospital executives. Why not build in this area a good modern convalescent and custodial home? Many patients in the four area hospitals recover sufficiently so they could easily be removed to a much less complicated, less expensive, but modern, good facility for convalescent care which could extend in many cases for weeks. Other persons from the hospitals or their own homes need

moderate nursing care plus maintenance, room, board, for short or longer periods. At present these people occupy elaborate and expensive general hospital beds costing either their insurance companies or themselves \$25.00 to \$40.00 a day. The attention just outlined could probably be furnished for \$6.00 or \$8.00, maybe less, and could be just as satisfactory, because while the institution mentioned would provide for first aid, patients needing full medical or nursing care suddenly or accidentally could be referred back to the general hospital. The convalescent center should be completely disassociated from either hospital. In that way, it could maintain itself in the price field contemplated.

Such an installation could easily be used by insurance-paid or private-paid patients and might greatly relieve the high cost of present hospital care for long-staying patients who have no other place to stay during disability or delayed rehabilitation. The convalescent problem or nursing home, as it now exists, is completely inadequate. The places are mostly old homes or other shelters, of which there are 480 registered in the state. This new medical center is an opportunity to experiment in making a satisfactory advancement in medical care for countless thousands.

The place and the time are here and now. We hope someone in the planning position will attempt just such a pioneering venture.

## VETERANS' HOMETOWN CARE

The care of veterans with service-connected disabilities has been a problem since the First World War. It was inconvenient and costly for the veteran to travel to selected places in the state where there was a Veterans Administration Facility. The expense was out of proportion, and the veteran decidedly discomforted. Ten year ago, the condition not having improved after the Second World War, the Michigan State Medical Society advocated a scheme by which the home-town doctors and hospitals might be used through special arrangements with the Administration to make the service available. The plan known then as the Michigan Plan was adopted. Michigan Medical Service, through its ideal association and represen-

## EDITORIAL

tation with the doctors, acted as intermediary, serving as the contractor with the Veterans Administration. Other states which had Blue Shield followed suit, and contracted for veterans' hometown care. Some states contracted directly.

Michigan Medical Service acted for the Veterans Administration and the doctors, servicing the program, paying the doctors and then billing the VA and being paid cost plus actual expense. That expense has been varied: around 5 to 6 per cent; the last year, 6.25 per cent. At the end of ten years, there being about eight or nine states still administering to the veterans under our plan, the Veterans Administration last November wrote to our President, William S. Jones, M.D., announcing the discontinuance of the use of Michigan Medical Service as an intermediary, and cancellation of the program to take effect July 1, 1957. Editorials and notes were prepared, a special meeting of the Executive Committee of the Council met in Battle Creek with Congressman August Johansen to make plans, and a conference was held in Chicago January 9, 1956, with representatives from Michigan, Wisconsin, South Carolina, Colorado, Oregon, and Washington. Michigan was represented by Michigan Medical Service officers and veterans organization officers.

A conference was held in Washington, D. C., on February 24, 1956, with the Administrator of Veterans' Affairs, Herbert V. Higley, Dr. Middleton (the Chief Medical Officer who wrote the notifying letter), Congressman Johansen, an assistant to Senator Potter, and John Castellucci, Executive Director of the National Blue Shield Commission. The delegation from Michigan consisted of W. S. Jones, M.D., President of the Michigan State Medical Society; L. Fernald Foster, M.D., Secretary; Hugh Brenneman, Public Relations Counsel; Wilfrid Haughey, M.D., Editor of THE JOURNAL of the Michigan State Medical Society, and President of Michigan Medical Service; Jay C. Ketchum, Executive Director of Michigan Medical Service; F. Gordon Goodrich, Assistant Executive Director of Michigan Medical Service; Joe Mann, Public Relations Director, Veterans of Foreign Wars, and Carl Seaman of the American Legion.

The conference developed the fact that the Veterans Administration was trying to save money, but the Michigan delegation was able to demonstrate that there could not be much saving, and that there would be considerable realigning and dissatisfaction on the part of the veterans being

served. Mr. Higley promised to reconsider. Another conference was held at the time of the Chamber of Commerce meetings at which Mr. Higley announced his entire satisfaction with the Michigan program and his content with its administration. He assured the group that the plan would be continued in Michigan. As of July 1, 1957, unless some other plans are made, Michigan will be the only state still giving our veterans hometown care by their own doctors, and serviced by Blue Shield.

The Washington Report on the Medical Sciences, May 14, 1956, says: The Veterans Administration's Department of Medicine and Surgery now has fee schedule arrangements with twenty-five State Medical Societies for outpatient care of beneficiaries. In nine other states, the agreement is made with the State Blue Shield Plan which acts as an intermediary for billings and collections. In states where no agreement is in force, the Catalog No. 5 Guide for charges for medical services is used by VA field stations in making compensation for fee basis medical care.

### STATE DEPARTMENT OF SOCIAL WELFARE

In March, 1956, after many months of study and experimentation the Michigan State Department of Social Welfare and its Medical Advisory Committee has revised form SB-54 and form SB-54A, making them much simpler and requiring the doctor to fill out a single form much less frequently. A diagnosis is required. Some months ago, we mentioned the necessity of sufficient description to justify the suitable determination by the medical advisor. The cost of medical care is to be estimated as needed for less than three months, or for more than three months. Drugs, diet, and nursing care may also be specified.

In addition to his maintenance allowance, the non-institutional patient receiving old age assistance, aid to the blind, or aid to the disabled may now be given \$3 per month for miscellaneous or non-chronic medical costs. If this is not sufficient for his needs, he will be allocated the amount his doctor specifies on Form SB-54 as chronic medical need, if within legal limits. This will continue as long as needed if, in turning in his Form SB-54A each three months, he demonstrates that he has secured the allowed medical care. Should he need more, a statement from his doctor will suffice.

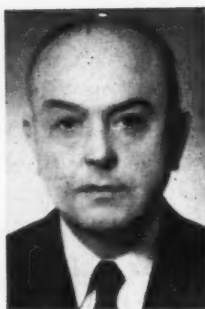
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O. ANDERSON, M.D.



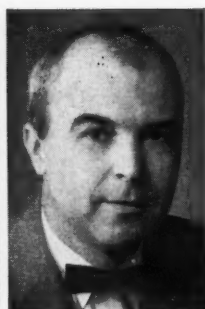
K. E. APPEL, M.D.



J. P. CAFFEY, M.D.



L. A. CALKINS, M.D.



E. P. CAWLEY, M.D.



D. E. CLARK, M.D.



F. A. COLLIER, M.D.



R. C. CONNELLY, M.D.

1956  
Guest  
Speakers



A. C. CORCORAN, M.D.



E. J. DECOSTA, M.D.



G. S. FITZ-HUGH,  
M.D.



J. W. HENDERSON,  
M.D.



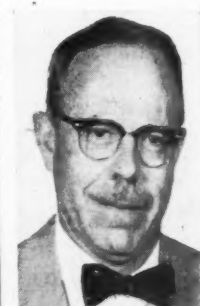
J. M. KAUFMAN, M.D.



M. R. KAUFMAN, M.D.



F. R. KEATING, JR.,  
M.D.



A. M. LARGE, M.D.



J. K. LATTIMER, M.D.



A. A. LIEBOW, M.D.



E. P. MCCULLAGH,  
M.D.



P. S. MACNEAL, M.D.



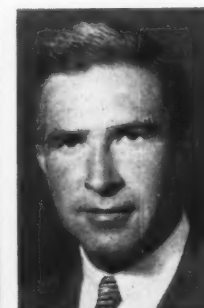
J. H. MEANS, M.D.



G. R. MENEELY, M.D.



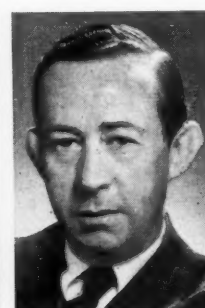
S. E. MILLER, M.D.



J. M. MURPHY, M.D.



O. S. ORTH, M.D.



C. A. POINDEXTER,  
M.D.



H. M. POLLARD, M.D.



M. PRINZMETAL, M.D.

# The 1956 Annual Session - Number 91

The MSMS Annual Session—already the envy of many state societies for its scope, practical value, and general excellence—will add to its reputation, for outstanding postgraduate medical education in 1956 when the 91st edition is presented in Detroit on September 26-27-28.

Maintaining the MSMS policy of packing practical value into each of its postgraduate and scientific meetings, every topic at the 1956 Annual Session will be applicable to clinical medicine. Diagnosis and treatment usable in daily practice will be stressed throughout.

M. A. Darling, M.D., of Detroit, is General Chairman and head of the Committee on Arrangements.

Teachers from across the nation will lecture at the six scientific assemblies and sixteen section meetings planned during the intensive three-day session. In all there will be thirty-one nationally-recognized speakers from twenty-three medical centers located in nineteen different cities.

Once again the Annual Session will open with General Practice Day on Wednesday, September 26, its varied program aimed at the interests of Michigan GP's.

At least seven ancillary and specialty groups will hold meetings and lecture sessions during the three-day period, supplementing the MSMS program.

All MSMS meetings, including the two-day session of the House of Delegates preceding the scientific assemblies, will be held in the Sheraton-Cadillac Hotel.

The technical and scientific exhibit this year will feature 102 displays, which also offer important educational opportunities to Annual Session registrants.

Daily discussion conference each noon will allow for personal consideration of cases and problems

with the lecturers. The entire lineup of speakers for each day will take part. These conferences have become one of the most popular attractions of the Annual Session since they were introduced several years ago.

Foremost non-scientific meeting during the Annual Session will be the traditional Officers' Night program on Wednesday evening, September 26, when new officers of MSMS will be introduced and inducted. Special awards also will be presented for outstanding service in medicine and health affairs. Highlight of the evening will be the Biddle Lecture by a well-known figure who will discuss a non-medical topic of vital concern to doctors of medicine. Officers' Night will be open to the families and guests of MSMS members.

An added highlight, new for 1956, will be the Officers' Night Banquet at 6:30 P.M. Wednesday, a subscription dinner sponsored by MSMS and its Woman's Auxiliary. MSMS officers, Woman's Auxiliary officers, and the Biddle Lecturer will be honored guests.

MSMS will be host Thursday evening, September 27, at a program of "after hours" amusement and entertainment during State Society Night. Dancing and a sparkling floor show will be among the attractions.

Members of medical organizations in neighboring states and the Province of Ontario have been invited to share the Annual Session with MSMS members, and early indications are that past attendance records will be threatened. Hotel accommodations may be at a premium and early reservations are urged.

The MSMS Annual Session is one of the major services offered by your State Medical Society, and one of the most valuable. . . . It's yours for the asking, Doctor!



H. S. RATTNER, M.D.



J. R. SCHENCKEN, M.D.



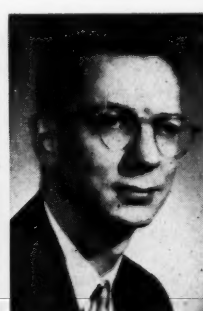
L. SCHIFF, M.D.



T. F. SCHLAEGEL, JR., M.D.



S. H. STURGES, M.D.



W. E. WHEELER, M.D.

# Michigan State Medical Society

## The Ninety-first Annual Session

SHERATON-CADILLAC HOTEL, DETROIT

September 24-25-26-27-28, 1956

### ANNUAL SESSION INFORMATION

#### DIRECTORY

**Headquarters**—Sheraton-Cadillac Hotel, Detroit

**Registration**—for House of Delegates: Sheraton-Cadillac Hotel, Detroit, Grand Ballroom Foyer (Fourth Floor) Monday, Sept. 24, 8:30 a.m.

**Scientific Assemblies**—Grand Ballroom—Wednesday, Thursday, Friday, September 26-27-28

**House of Delegates**—Monday-Tuesday, September 24-25 (Grand Ballroom, Sheraton-Cadillac Hotel)

**Exhibits**—Wednesday-Thursday-Friday, September 26-27-28, Fourth Floor, Sheraton-Cadillac Hotel)

**Press Room**—Suite 500, Sheraton-Cadillac Hotel

**Woman's Auxiliary Headquarters**—Fort Shelby Hotel, Detroit

**Michigan State Medical Assistants Society Headquarters**—Detroit-Leland Hotel, Detroit

● **REGISTER**—Fifth Floor, Sheraton-Cadillac Hotel—as soon as you arrive.

#### Hours:

Tuesday, September 25, 1:00 p.m. to 5:00 p.m.

Wednesday, September 26, 7:30 a.m. to 5:15 p.m.

Thursday, September 27, 8:30 a.m. to 5:15 p.m.

Friday, September 28, 8:30 a.m. to 3:30 p.m.

● **NO REGISTRATION FEE FOR MEMBERS OF MSMS AND OTHER STATE MEDICAL ASSOCIATIONS, AMA AND CANADIAN MEDICAL ASSOCIATION.**

Admission will be by badge only to all Scientific Assemblies, Section Meetings, Discussion Conferences and the Exhibition. Please present your MSMS or other State Medical Association, AMA, or CMA Membership card to expedite your registration. We wish to save your time.

● **MICHIGAN DOCTORS OF MEDICINE**, in practice but who are not members of MSMS, if listed in the American Medical Directory, may register as guests upon payment of \$25.00. This amount will be credited to them as dues in the Michigan State Medical Society FOR THE BALANCE OF 1956 ONLY, provided they subsequently are accepted as members by the County Medical Society in whose jurisdiction they practice.

M. A. Darling, M.D., of Detroit, is General Chairman of the 1956 MSMS Annual Session.

● **DOCTOR**, register Tuesday! Registration of physicians will be held Tuesday afternoon from 1:00 to 5:00 p.m.—as well as on Wednesday-Thursday-Friday, during the 1956 MSMS Annual Session. The Tuesday afternoon registration hours are arranged so that physicians may avoid waiting in line Wednesday morning before the opening Assembly.

We recommend to Detroit physicians—and those who arrive in Detroit on Tuesday—that they register Tuesday, September 25, from 1:00 to 5:00 p.m., Fifth Floor, Sheraton-Cadillac Hotel.

#### SECTION MEETINGS

##### WEDNESDAY, SEPTEMBER 26

5:00 to 6:00 p.m. General Practice  
Occupational Health  
Obstetrics-Gynecology  
Pediatrics  
Public Health & Preventive Medicine  
Urology

##### THURSDAY, SEPTEMBER 27

5:00 to 6:00 p.m. Gastroenterology-Proctology  
Nervous and Mental Diseases  
Ophthalmology  
Otolaryngology  
Radiology  
Surgery

##### FRIDAY, SEPTEMBER 28

5:00 to 6:00 p.m. Anesthesiology  
Dermatology-Syphilology  
Medicine  
3:00 to 9:00 p.m. Pathology

● **TELEPHONE SERVICE**—Special lines to handle local and long distance telephone service for registrants at the MSMS meeting will be installed on the Fourth Floor, near Grand Ballroom, Sheraton-Cadillac Hotel. Call Woodward 1-8000.

● **GUEST ESSAYISTS** are very respectfully requested not to change time of their lecture with another speaker without the approval of the Assembly Chairman. This request is made in order to avoid confusion and dis-appointment on the part of members of the audience.

● **CHECK ROOM**—Fifth Floor, Sheraton-Cadillac Hotel near elevators.

#### NEW INFORMATION IN THE EXHIBIT

Many items of interest or education will be found in the large exhibit of 102 technical displays. The Exhibit Section at MSMS Annual Sessions is as important, informative and desirable to most doctors of medicine as the scientific papers presented in the Assembly room.

Doctor, stop at every booth—you'll be surprised how much you'll learn! No high-pressure salesman but a courteous well-informed exhibitor will greet you and supply you with some valuable information helpful to your patients.

## ANNUAL SESSION INFORMATION

● **BANQUET—Officers' Night**—Wednesday, September 26, 1956. At 6:30 p.m. (Informal), Grand Ballroom, Sheraton-Cadillac Hotel, Detroit. All registrants and their ladies are cordially invited.

● **POSTGRADUATE CREDITS ARE GIVEN TO EVERY MSMS member** who attends the Annual Session.

**INFORMATION OF PRACTICAL VALUE IN DAILY PRACTICE** will be found at the Michigan State Medical Society Annual Session. All subjects on the MSMS Annual Session Program are applicable to clinical medicine. They stress diagnosis and treatment in everyday practice.

● **TRANSPORTATION**—The C & O Streamliners afford a convenient means of transportation to the MSMS Annual Session in Detroit for hundreds of physicians located in the central and western parts of the State.

● **PARKING**—Do not park on Detroit's streets. Inside parking at a convenient distance from the Sheraton-Cadillac Hotel, is available at the Book Tower Garage, 333 State, the DAC Garage, 1754 Randolph, and the Grand Circus Garage, 1776 Randolph.

● **CABARET-STYLE DANCE AND FLOOR SHOW**, with the compliments of the Michigan State Medical Society, will be held in the Grand Ballroom of the Sheraton-Cadillac Hotel at 10:30 p.m., Thursday, September 27. All who register, and their ladies, will receive a card of admission and are cordially invited to attend.

● **THE DETROIT HISTORICAL MUSEUM**, Woodward at Kirby, Detroit (TEmple 3-5410) invites all MSMS registrants to visit the Museum while in Detroit. Hours: 1:00 p.m. to 10:00 p.m. Tuesday through Friday.

### MICHIGAN MEDICAL SERVICE MEMBERS' MEETING

Blue Cross-Blue Shield Building  
441 East Jefferson Ave., Detroit

Tuesday, September 25, 1956

Coincident with MSMS Annual Session

11:45, 12:00, 12:15, buses will leave Sheraton-Cadillac Hotel

12 Noon-12:30 p.m.—"See Your Plan In Action"

12:30 p.m.—Preprandial—Private Dining Room, Fifth Floor

1:00 p.m.—Lunch

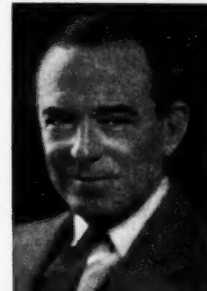
2:00 p.m.—Meeting of Corporation—Auditorium

All MSMS Delegates are members of Michigan Medical Service Corporation and are expected to attend the MMS Luncheon and Annual Meeting. The MMS Annual Meeting is open to ALL members of the medical profession who are cordially invited to attend.

### THREE DISCUSSION CONFERENCES



HAROLD C. MACK, M.D., Detroit, Leader on Wednesday, September 26, 1956



FREDERICK A. COLLIER, M.D., Ann Arbor, Leader on Thursday, September 27, 1956



HAROLD HENDERSON, M.D., Detroit, Leader on Friday, September 28, 1956

Three quiz periods will be held Wednesday-Thursday-Friday, September 26-27-28, Grand Ballroom, Sheraton-Cadillac Hotel, 12:00 noon to 1:00 p.m. with all the guest speakers of the day on the platform.

An opportunity to ask questions concerning the presentations of the guest essayists, or to discuss an interesting case with them, is provided at these Discussion Conferences.

● **THE SCIENTIFIC PRESS RELATIONS COMMITTEE** is composed of: H. F. Dibble, M.D., Detroit, Chairman; L. J. Bailey, M.D., Birmingham; A. B. Gwinn, M.D., Hastings; J. J. Lightbody, M.D., Detroit; and M. R. Weed, M.D., Detroit.

● **THE HOUSE OF DELEGATES PRESS RELATIONS COMMITTEE** is composed of: J. E. Livesay, M.D., Flint, Chairman; H. F. Dibble, M.D., Detroit; L. Fernald Foster, M.D., Bay City; A. B. Gwinn, M.D., Hastings; and K. H. Johnson, M.D., Lansing.

● **THE MSMS HOUSE OF DELEGATES** convenes Monday, September 24, at 10:00 a.m., Grand Ballroom, Sheraton-Cadillac Hotel; it will hold three meetings on Monday, September 24, at 10:00 a.m., 2:00 p.m. and at 8:00 p.m.; also two meetings on Tuesday, September 25, at 9:30 a.m. and at 8:00 p.m.

● **PAPERS WILL BEGIN AND END ON TIME**—Believing there is nothing which makes a scientific meeting more attractive than by-the-clock promptness and regularity, all meetings will open exactly on time, all speakers will be required to begin their papers exactly on time and to close exactly on time in accordance with the schedule in the program. All who attend the meeting, therefore, are requested to assist in attaining this end by noting the schedule carefully and being in attendance accordingly. Any member who arrives five minutes late to hear any particular paper will miss exactly five minutes of that paper!

## ANNUAL SESSION INFORMATION

### GENERAL PRACTICE DAY

#### 1956 MSMS Annual Session

Wednesday, September 26, will be "General Practice Day" at the Detroit Session of the Michigan State Medical Society.

The Assembly subjects on the first day of the convention are especially dedicated to the interest of general practitioners.

The General Practice Section also will meet on Wednesday at the Sheraton-Cadillac Hotel.

● **THE FOURTH BEAUMONT LECTURE OF THE MICHIGAN STATE MEDICAL SOCIETY** will be presented by Leon Schiff, M.D., of Cincinnati, Ohio, on Thursday, September 27, 2:00 p.m. Doctor Schiff's subject will be "Clues and Pitfalls in the Diagnosis of Jaundice."

● **THE TECHNICAL EXHIBITS** will open daily at 8:45 a.m. and close at 5:15 p.m., except on Friday when the break-up is at 3:30 p.m. Frequent intermissions to view the educational exhibits have been arranged before, during, and after the Assemblies. Bring to the MSMS Convention a "WANT LIST" of your needs and place an order with an MSMS exhibitor.

● **A CONCENTRATED THREE-DAY POSTGRADUATE COURSE—A CAPSULE OF GREAT VALUE TO THE MICHIGAN PRACTITIONERS OF MEDICINE—THE MSMS ANNUAL SESSION OF 1956.**

### MEETINGS OF SPECIAL SOCIETIES, ALUMNI AND AUXILIARY GROUPS

Tuesday, September 25, 1956

#### 1. MICHIGAN BRANCH, AMERICAN ACADEMY OF PEDIATRICS—

Auditorium, Henry Ford Hospital

Chairman—HARRY A. TOWSLEY, M.D., Ann Arbor

10:00 "Diabetes in Pregnancy. Delivery and Post-natal Infant Care."

C. PAUL HODGKINSON, M.D., Obstetrician-in-Chief, Henry Ford Hospital, Detroit.

10:30 "Neonatal Mortality."

RUBEN MEYER, M.D., Children's Hospital, Detroit. Chairman, Wayne County Infant Mortality Study.

11:00 "Current Cases."

JOSEPH A. JOHNSTON, M.D., Pediatrician-in-Chief, Department of Pediatrics, Henry Ford Hospital, Detroit.

P.M.

12:45 Luncheon. Henry Ford Hospital dining room.

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Chairman—EDGAR E. MARTMER, M.D.

P.M.

2:00 "Emotional Care of the Hospitalized Child."

ROBERT M. HEAVENRICH, M.D., Pediatrician-in-Chief, St. Mary's Hospital, and Saginaw General Hospital, Saginaw, Michigan.

2:30 "Salvaging the Mentally Handicapped."

ERNEST H. WATSON, M.D., University Hospital, Ann Arbor. Associate Professor of Pediatrics and Communicable Disease.

3:00 "Psychosomatic Problems in Children."

STUART M. FINCH, M.D., Physician-in-Chief, Children's Institute, Ann Arbor.

3:30 Discussion of Preceding Papers.

4:00 Business meeting.  
Election.  
Committee Reports.

6:00 Cocktail Hour and Dinner. Sheraton-Cadillac Hotel, English Room.  
Courtesy of Baker Laboratories and Gerber Products Company.

8:30 "Carcinoma of the Thyroid in Children, and Prior Regional Irradiation."  
JOHN CAFFEY, M.D., Babies Hospital, New York City. Professor of Clinical Pediatrics, College of Physicians and Surgeons, Columbia University.

Wednesday, September 26, 1956

2. **THE MICHIGAN REGIONAL COMMITTEE ON TRAUMA, AMERICAN COLLEGE OF SURGEONS**, will present a scientific program Wednesday, September 26, in the Pan American Room of the Sheraton-Cadillac Hotel. The meeting starting at 2:00 P.M. will feature eight speakers discussing a variety of trauma subjects.

Dr. Charles Johnston, President of the American Association for the Surgery of Trauma, will present some of the highlights in the history of surgery for trauma. Dr. Nicholas Gimbel of Wayne University Medical School will discuss some features of the handling of mass casualties.

Wound healing is another of the topics of interest. All physicians are invited.

3. **MSMS SECTION ON GENERAL PRACTICE**—Section meeting from 5:00 to 6:00 p.m. in the English Room; reception at 6:00 p.m. in the Book-Casino; dinner 7:00 to 8:00 p.m. in the English Room, Sheraton-Cadillac Hotel. Following the meeting of the General Practice Section, there will be an election of officers for the ensuing year. The reception in the Book-Casino is for banquet ticket holders. Dinner speaker is Kenneth B. Babcock, M.D., Chicago, Illinois; "Present Status of General Practice Sections in Hospitals."

4. **MSMS SECTION ON PEDIATRICS**—Section meeting from 5:00 to 6:00 p.m.; reception and dinner beginning at 6:30 p.m.—all in the Pan American Room of the Sheraton-Cadillac Hotel. Attention all pediatricians and others interested—you are cordially invited to participate in the Section meeting, reception and dinner. Write Bernard Bernbaum, M.D., 17320 Livernois, Detroit.

5. **MSMS SECTION ON UROLOGY AND DETROIT BRANCH, AMERICAN UROLOGICAL ASSOCIATION**—Section meeting from 5:00 to 6:00 p.m.; reception and dinner beginning at 6:30 p.m.—all in Parlors G and H of the Sheraton-Cadillac Hotel. John K. Lattimer, M.D., New York City, will speak on "Retropubic Radical Prostatectomy for Cancer."

6. **MSMS SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE**—Otis L. Anderson, M.D., Assistant Surgeon General and Chief, Bureau of State Services of the U. S. Public Health Service, will be the speaker at the meeting of the Section on Public Health and Preventive Medicine, 5:00 p.m. in the Sheraton-Cadillac Hotel. Doctor Anderson will speak on "Chronic Diseases Challenge to Public Health." Cocktails will be served at 6:30 p.m. followed by a subscription dinner at 7:00 p.m. in the Sheraton-Cadillac Hotel.

All members of the Michigan State Medical Society are invited to this meeting and all other functions of the Section on Public Health and Preventive Medicine.

7. **MSMS SECTION ON OCCUPATIONAL HEALTH**—Section meeting from 5:00 to 6:00 p.m.; reception and dinner beginning at 6:30 p.m.—all in the Sheraton-Cadillac Hotel.

ANNUAL SESSION INFORMATION

8. MICHIGAN DIABETES ASSOCIATION—Dinner meeting beginning at 6:30 p.m. (cocktails) in the Sheraton Room of the Sheraton-Cadillac Hotel.

Thursday, September 27, 1956

9. ALPHA KAPPA KAPPA—Breakfast meeting at 7:30 a.m. in the Sheraton Room of the Sheraton-Cadillac Hotel.
10. MSMS COMMITTEE OF PAST PRESIDENTS—A luncheon meeting of the Committee of Past Presidents will be held at 12:00 noon in Parlor K of the Sheraton-Cadillac Hotel.
11. MSMS SECTION ON GASTROENTEROLOGY AND PROCTOLOGY—Section meeting from 5:00 to 6:00 p.m. in the English Room, Sheraton-Cadillac Hotel; reception and dinner beginning at 6:30 p.m., at the Statler Hotel honoring Leon Schiff, M.D., and Associates on the Panel. The Panel presented during the Section meeting is entitled "Medical and Surgical Problems of Liver Disease." The Moderator is Richard C. Connelly, M.D., Detroit. Participants are: Leon Schiff, M.D., Cincinnati, Ohio; H. Marvin Pollard, M.D., Ann Arbor, and Alfred M. Large, M.D., Detroit.
12. MSMS SECTION ON NERVOUS AND MENTAL DISEASES—Section meeting from 5:00 to 6:00 p.m.; reception and dinner beginning at 6:30 p.m.—all in the Pan American Room of the Sheraton-Cadillac Hotel.
13. MSMS SECTION ON OPHTHALMOLOGY—The Section meeting in Ophthalmology this year will be a departure from the usual program in that it will be a symposium on neurology of the eye at 5:00 p.m. followed by reception at 6:30 p.m. and dinner at 7:00 p.m. in the Sheraton Room of the Sheraton-Cadillac Hotel. The ladies are invited and urged to attend.
14. MSMS SECTION ON RADIOLOGY—Section meeting from 5:00 to 6:00 p.m. in Parlor J; reception and dinner beginning at 6:30 p.m. in Parlors G and H of the Sheraton-Cadillac Hotel. The radiologists of the state are urged to attend their Section meeting.
15. WAYNE STATE UNIVERSITY ALUMNI DINNER—reception at 6:00 p.m. followed by dinner at 7:00 p.m. in the English Room of the Sheraton-Cadillac Hotel. All Alumni, Faculty, and friends of Wayne State University are cordially invited to attend.
16. MICHIGAN CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS—Paul H. Hollinger, M.D., Professor of Laryngology, Rhinology and Otolaryngology, University of Illinois, will address the Michigan Chapter of the American College of Chest Physicians on "The Bronchoscopic Appearance of Bronchopulmonary Lesions." A subscription dinner will be served at 6:00 p.m. in the Sheraton-Cadillac Hotel. Dr. Hollinger's talk is scheduled for 8:00 p.m. Members of the Wayne County Medical Society are cordially invited to attend this meeting.
17. BOARD OF DIRECTORS, MICHIGAN ACADEMY OF GENERAL PRACTICE—12:00 noon luncheon-meeting in Parlor F of the Sheraton-Cadillac Hotel.

Friday, September 28, 1956

18. MICHIGAN PATHOLOGICAL SOCIETY—3:00 p.m. meeting; A Slide Seminar on Diseases of the Lower Respiratory Tract presented by Averill A. Liebow, M.D., of New Haven, Connecticut; reception and dinner beginning at 6:30 p.m.—all in the English Room of the Sheraton-Cadillac Hotel.

HOTEL RESERVATIONS

MICHIGAN STATE MEDICAL SOCIETY

91st Annual Session

Detroit, September 26-27-28, 1956

The reservation blank below is for your convenience in making your hotel reservations in Detroit. Please send your application to the Committee on Hotels for MSMS Convention, Att: B. Van DeKeere, Sheraton-Cadillac Hotel, Detroit, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Committee on Hotels by sharing a room with another registrant, when convenient.

Committee on Hotels,  
Michigan State Medical Society  
c/o Sheraton-Cadillac Hotel  
Detroit, Michigan

Att: D. J. Gibb

Please make hotel reservation(s) as indicated below:

\_\_\_\_\_ Single Room(s) \_\_\_\_\_ persons  
\_\_\_\_\_ Double Room(s) for \_\_\_\_\_ persons  
\_\_\_\_\_ Twin-Bedded Room(s) for \_\_\_\_\_ persons

Arriving September \_\_\_\_\_ hour \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

Leaving \_\_\_\_\_ hour \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

Hotel of First Choice: \_\_\_\_\_

Second Choice: \_\_\_\_\_

Name and addresses of all applicants including person making reservation:

| Name  | Address | City  | State |
|-------|---------|-------|-------|
| _____ | _____   | _____ | _____ |
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| _____ | _____   | _____ | _____ |

Date \_\_\_\_\_ Signature \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

# ANNUAL SESSION INFORMATION

## Women's Organizations

### WOMAN'S AUXILIARY, MICHIGAN STATE MEDICAL SOCIETY

#### Thirtieth Annual Meeting

September 24-25-26-27-28, 1956

Fort Shelby Hotel

Detroit, Michigan

Monday, September 24, 1956

A.M.  
10:30 Report of the Auxiliary President to the House of Delegates of the Michigan State Medical Society

Tuesday, September 25, 1956

11:00 Executive Committee Meeting  
Noon  
12:00 Registration, Hotel Fort Shelby  
12:00 Hospitality Room opens  
P.M.  
12:30 Organizational Luncheon and Meeting of District Directors, Mrs. C. Allen Payne, First Vice President, presiding  
3:00 Meeting of 1955-56 and 1956-57 State Chairmen. Mrs. A. C. Stander, President-Elect, presiding  
6:30 Past Presidents' and Secretaries' Dinner

Wednesday, September 26, 1956

A.M.  
9:00 Pre-Convention Board Meeting, Crystal Room, Hotel Fort Shelby (For 1955-56 State officers, Chairmen and County Presidents). Chairman: Mrs. Delbert M. MacGregor, President  
10:30 Formal Opening of the 30th Annual Meeting of the Woman's Auxiliary to the Michigan State Medical Society. Mrs. Delbert M. MacGregor presiding  
12:30 Past Presidents' Luncheon—Honoring Past Presidents of the Woman's Auxiliary to MSMS and representatives of the MSMS. Guest Speaker to be announced

Thursday, September 27, 1956

A.M.  
9:00 General Session resumes—Crystal Room, Hotel Fort Shelby  
P.M.  
12:30 Inaugural Luncheon  
2:30 Post-Convention Board Meeting (For all 1956-57 Officers, Chairmen and County Presidents).  
4:00 Mrs. A. C. Stander presiding

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### MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

Detroit-Leland Hotel, Detroit, Michigan  
September 26-27, 1956

Wednesday, September 26, 1956

A.M.  
9:00 Registration .....Lobby  
10:00 Mr. Walter Panich, Detroit Bureau of Narcotics "Narcotics Regulations" .....Colonial Room  
11:00 James D. Fryfogle, M.D., Detroit, Cardio-vascular and Thoracic Surgeon "Facts and Figments of Heart Surgery" .....Colonial Room  
P.M.  
12:30 Luncheon—Hostess: Miss Adeline French Courtesy of Michigan Medical Service .....Jade Room  
2:00 Annual Business Meeting and Election of Officers .....Colonial Room  
4:00 View Exhibits—Sheraton-Cadillac Hotel  
6:00 Social Hour—Hostess: Mrs. Cora Steckel Courtesy of Parke-Davis & Co. ....Jade Room  
7:00 Banquet—Hostess: Miss Grace Malkey .....India Room  
Les Payne and the James Sisters will entertain during Social Hour and Banquet

Thursday, September 27, 1956

A.M.  
9:00 Registration .....Lobby  
10:00 Harold A. Wallace, St. Louis, Missouri, President American Trade Association Executives "Making Yourself More Valuable" .....Colonial Room  
11:00 W. W. Bauer, M.D., Chicago, Director of the Bureau of Health Education "Stop Annoying Your Patients" ..Colonial Room  
P.M.  
12:30 Presidents Luncheon—Hostess: Miss Marlouise Redman .....Jade Room  
Introduction of Officers—Mrs. Elizabeth Peck Door Prizes  
2:30 Fashion Show and Tea .....Colonial Room  
Courtesy of Demery's  
4:00 View Exhibits—Sheraton-Cadillac Hotel

Anyone actively employed in a technical or in an administrative capacity in the office or laboratory of a member of the Michigan State Medical Society; also, administrative employees in the offices of Medical Hospitals or Medical Laboratories of the State of Michigan is welcome to attend all activities of the Michigan State Medical Assistants Society's meetings. All activities will be held at the Detroit Leland Hotel, Detroit, Michigan. Registration Fee for Non-Members is \$2.00.

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PLEASE MAKE HOTEL RESERVATIONS AS SOON AS POSSIBLE FOR BEST ACCOMMODATIONS.

Write: Reservations, Detroit-Leland Hotel, Cass and Bagley Avenues, Detroit 26, Michigan.

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Please make all other reservations with the following:  
Luncheon sponsored by Michigan Medical Service.  
Reservations by mail to: Miss Adeline French, 8-265 General Motors Building, Detroit 2, Michigan.

Banquet—\$5.10 (tax and tip included)  
Reservations by mail, accompanied by check or money order to: Miss Grace Malkey, 655 Fisher Building, Detroit 2, Michigan.

Presidents Luncheon—\$3.00 (tax and tip included)  
Reservations by mail, accompanied by check or money order to: Miss Marlouise Redman, 541 David Whitney Building, Detroit 26, Michigan.

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# Michigan State Medical Society

## The Ninety-first Annual Session

SHERATON-CADILLAC HOTEL, DETROIT

SEPTEMBER 26-27-28, 1956

### Programs of Assemblies and Sections

#### WEDNESDAY MORNING

September 26, 1956

##### First Assembly

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: H. B. RICE, M.D., Detroit

Secretary: J. E. WENTWORTH, M.D., Flint

##### GENERAL PRACTICE DAY

A.M.

9:00

##### "DISEASES OF THE ADRENAL GLAND"

PERRY S. MACNEAL, M.D., Philadelphia, Pennsylvania

*Assistant Professor of Clinical Medicine, Jefferson Medical College; Physician to the Pennsylvania Hospital and to the Benjamin Franklin Clinic, Philadelphia; Physician-in-Chief, Burlington County Hospital, Mt. Holly, New Jersey*

An increasing knowledge of the metabolic functions of the adrenal gland and improved methods of study in relation to abnormal functions of this gland have completely changed our concept of diagnosis and treatment during the past few years. It was just a short time ago that these diseases could only be diagnosed by inference and deduction and treated with very expensive hypodermic medications. Now they are being diagnosed by clear cut clinical observations and laboratory procedures and treated inexpensively with oral drugs. Hyperfunctioning syndromes of the adrenal gland can be diagnosed specifically and the various causes of adrenal hyperfunction (carcinoma, adenoma, hyperplasia and pituitary hyperactivity) can be fairly well differentiated. Specific medical and surgical therapy for these conditions is now a practical measure. Tumors of the adrenal medulla producing hypertension can be separated from the ordinary group of "essential" hypertensive cases so that specific surgical management can be undertaken.

9:30

##### "THE CLINICAL PROBLEM OF PRIMARY HYPERPARATHYROIDISM"

FRANCIS R. KEATING, JR., M.D., Rochester, Minnesota

*Professor of Medicine, Mayo Foundation Graduate School; Consultant in Medicine and Head of Section, Mayo Clinic*

As originally described primary hyperparathyroidism was considered a very rare demineralizing disease of bone. Albright later demonstrated that it was much commoner than supposed and showed that it was usually to be sought not as bone disease but solely through its renal complications. Recent experience indicates that it may occur without either bone or renal manifestations and in fact often does not produce any symptoms until some complication arises. Because of the potential hazard that the persistence of hypercalcemia poses to renal function and, therefore, to life expectancy, the recognition of primary hyperparathyroidism is imperative even in the absence of symptoms.

The symptoms of primary hyperparathyroidism, when there are any, may be cataloged under three headings: (1) those due to hypercalcemia per se (these are present only in those uncommon instances in which the concentration of calcium in the serum is dangerously high); (2) those due to the urinary complications per se, and (3) those resulting from the skeletal complications per se. In any one patient many of the symptoms

will be absent and a number of patients have been observed in whom all of them are absent.

From the beginning the sine qua non for the diagnosis of primary hyperparathyroidism has been the demonstration of a pathologic elevation of serum calcium which could not be accounted for on some alternative basis, such as hypervitaminosis D<sub>2</sub>, myeloma, sarcoid or carcinomatosis. Usually but not invariably the level of serum inorganic phosphorus is reduced also. The extent of these chemical abnormalities need differ from the normal by a very minute amount indeed. In cases in which clinical findings are scanty and the hypercalcemia and hyperphosphatemia are minimal or equivocal, supplementary diagnostic information is needed urgently. Other procedures which have been of assistance and which include quantitative measurement of urinary excretion of calcium in the urine (so-called Aub test), the calcium-loading test, test of tubular reabsorption of phosphate and similar measures will be reviewed in detail. When such diagnostic facilities are diligently applied and the disease is sought in all conditions likely to harbor it, such as malacic disease of bone, nephrocalcinosis, nephrolithiasis, polyuria, polydipsia and similar situations, what formerly was regarded as a rare endocrinopathy proves to be a relatively common one in clinical medicine.

10:00

##### INTERMISSION TO VIEW EXHIBITS

11:00

##### "THE GENERAL PRACTITIONER IN CHRONIC DISEASE AND DISABILITIES IN INDUSTRY"

SEWARD E. MILLER, M.D., Washington, D. C.

*Medical Director, Chief, Division of Special Health Services, U. S. Public Health Service*

The role of the general practitioner in the prevention and amelioration of chronic disease and disability in industry has marked social and economic overtones. Striking during the productive period of life, chronic diseases are estimated to cause more than a billion days of lost time each year. The general practitioner's burden of responsibility can be eased, however, by utilizing the resources available in the community and in industry for the early detection and management of chronic disease. These aides are available in four major areas: the prevention of exposures and conditions of work which may lead to chronic diseases, the proper placement of workers to avoid the aggravation of existing chronic diseases, the provision of preventive health services in industry for early detection, and the rehabilitation and restoration of the disabled patient to as productive and full a life as possible.

Various chronic diseases are known to be associated with specific occupational exposures. In the respiratory disease group, for example, are silicosis and silico-tuberculosis, asbestosis, and bagassosis. For assistance in making a differential diagnosis, when the occupation may be implicated, the general practitioner should turn to the industrial physician, or, if none, to the official occupational health agency in his State, for expert advice on the substances and processes used in that particular industry. The industrial physician is also an invaluable ally of the general practitioner in the early referral of workers found to be suffering from non-occupational chronic diseases and in the proper job placement of such individuals. For the more advanced cases, requiring restoration, rehabilitation facilities lend further effective support to the general practitioner in helping his patient achieve maximum function. The experience of work classification centers gives abundant evidence that it is possible for a majority of chronic disease victims to lead productive, useful lives when they are placed in suitable jobs and are under a proper medical regimen.

JULY, 1956

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# PROGRAM

11:30 "CHEMOTHERAPY OF RENAL TUBERCULOSIS"  
JOHN K. LATTIMER, M.D., New York, New York

*Professor of Urology, Columbia University College of Physicians and Surgeons; Director, Urological Service, Presbyterian Hospital, N. Y. C.; Director, Squier Urological Clinic; Director, Research Unit for Genito-Urinary Tuberculosis, Kingsbridge Veterans Administration Hospital*

Renal tuberculosis is a lethal form of the disease which is now successfully treated with combinations of anti-tuberculosis drugs. Medical treatment has been so successful that nephrectomy and partial nephrectomy are rarely necessary. Four, five and ten year follow-up statistics will be presented on patients treated with combinations of Streptomycin, PAS and Isoniazid.

12:00 END OF FIRST ASSEMBLY

## WEDNESDAY NOON September 26, 1956

12:00 noon to 1:00 p.m.

### Discussion Conference

Grand Ballroom, Sheraton-Cadillac Hotel

*Leader:* HAROLD C. MACK, M.D., Detroit  
*Participants:* OTIS ANDERSON, M.D., Washington, D. C.; JOHN P. CAFFEY, M.D., New York, New York; EDWIN J. DECOSTA, M.D., Chicago, Illinois; FRANCIS R. KEATING, JR., M.D., Rochester, Minnesota; JOHN K. LATTIMER, M.D., New York, New York; PERRY S. MACNEAL, M.D., Philadelphia, Pennsylvania; SEWARD E. MILLER, M.D., Washington, D. C.; and SOMERS H. STURGIS, M.D., Boston, Massachusetts.

## HOTEL RESERVATIONS

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91st ANNUAL SESSION

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## WEDNESDAY AFTERNOON September 26, 1956

### Second Assembly

Grand Ballroom, Sheraton-Cadillac Hotel

*Chairman:* BERNARD BERNBAUM, M.D., Detroit  
*Secretary:* J. F. HARROLD, M.D., Lansing

P.M.  
2:00

### "INFANTILE CORTICAL HYPEROSTOSIS; THE CHRONIC AND THE PRENATAL TYPES"

JOHN P. CAFFEY, M.D., New York, New York  
*Professor of Radiology, College of Physicians and Surgeons, Columbia University; Radiologist to Babies and Presbyterian Hospitals and the Vanderbilt Clinic*

The clinical and radiographic features of infantile cortical hyperostosis have become well known during the last eleven years. All of the early cases were relatively mild; the disease appeared to be self limited and recovery complete. With more experience chronic and recurring cases are being met with and there have been several deaths. One of the cardinal features of the disease has been the early onset, always prior to the sixth month of life. During the last three years, several cases have been identified in utero. This discussion will be directed chiefly to the findings in prenatal and in chronic types of the disease. The therapeutic values of corticotropin will also be emphasized.

2:30

### "PSYCHOSOMATIC ASPECTS OF GYNECOLOGY"

SOMERS H. STURGIS, M.D., Boston, Massachusetts

*Clinical Professor of Gynecology, Harvard Medical School; Surgeon (Gynecology), Head of Department, Peter Bent Brigham Hospital, Boston; Consultant in Gynecology, Children's Medical Center, Boston*

In the past fifty years, tremendous strides have been made in various aspects of the specialty of gynecology, more particularly in the endocrine, surgical and psychiatric knowledge of causes for and treatment of women's diseases. Today it is not sufficient to be a specialist in only one of these important facets of this specialty. Today gynecologists and obstetricians must recognize their responsibility in the state of health of the women of this country and the stability, or lack of it, that American women must provide for the American family unit.

In the office practice of gynecology a minority of patients are those who present themselves needing the expert care of a pelvic surgeon. Another minority also present endocrine problems that demand a knowledge of the interaction of the hormones that play upon the reproductive organs. Yet, almost every woman who seeks the advice of a gynecologist presents emotional overtones and psychological manifestations of difficulties focused on the reproductive function. It thus becomes more important perhaps than any other feature of the training of our gynecologists of the future to give them an awareness of the connotations and implications of this in dysfunctions and disorders of the reproductive tract.

Case reports are presented to illustrate the complexity of these problems in which psychological difficulties are combined in various ways with endocrine or surgical factors the satisfactory resolution of which demands, above all, an awareness of the overwhelming importance of psychological factors in gynecologic disease.

3:00

### INTERMISSION TO VIEW EXHIBITS

4:00

### "THE THYROID GLAND IN PREGNANCY"

EDWIN J. DECOSTA, M.D., Chicago, Illinois

*Attending Obstetrician and Gynecologist, Passavant Memorial Hospital; Associate Professor, Obstetrics and Gynecology, Northwestern University Medical School*

Any discussion of the thyroid gland with relation to obstetrical and gynecological problems must consider

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4:30

5:00

July.

## PROGRAM

both hypo- and hyperfunction. A great deal has been written on the subject over a period of many years but much remains to be said.

It is generally accepted that the ten-fold frequency of toxic goiter in the female, when compared to the male, and the so-called physiological enlargement of the thyroid at puberty, during pregnancy and at the menopause, are indicative of an intimate relationship between the thyroid and reproductive endocrine systems. The time-honored and frequent use of thyroid extract in the treatment of menstrual abnormalities and infertility indicates acceptance of therapeutic value. But is this so? Actually there is little to indicate that thyroid extract has any merit in the euthyroid individual. In fact, there is the suggestion that the use of thyroid extract in normal individuals may be harmful and undesirable. On the other hand, frank hypothyroidism is considered a legitimate indication for specific thyroid therapy.

The diagnosis of abnormalities of thyroid function depends largely upon the history and physical findings, confirmed by one or more of the following laboratory studies: (1) basal metabolic rate, (2) determination of the protein bound iodine of the plasma, and (3) determination of radioactive iodine absorption by the thyroid gland or that excreted from the body.

Menstrual disorders do occur in association with both hyper- and hypofunction. Most often hyperthyroidism is associated with oligomenorrhea or amenorrhea while hypothyroidism, in contradiction to the teaching of many, seems to be associated most frequently with excessive menstrual flow. Both conditions respond to proper therapy when the thyroid gland is the cause of the abnormality.

In considering the effects of the thyroid on gestation, several interesting questions arise. If pregnancy has been achieved in the face of hypothyroidism, is the administration of thyroid extract of any danger to the fetus? If pregnancy and hyperthyroidism coexist, can antithyroid drugs be used? What about I<sub>131</sub>, or should the patient be carried with iodine until after delivery? Do these drugs have untoward effects on either the fetus or mother? Do the thiouracils cause goiter in the newborn? Will I<sub>131</sub> given the mother produce a cretin as it does in dogs? Will therapeutic doses of iodine injure the fetal thyroid? Is surgery preferable to medicinal therapy during pregnancy, and if so, under what circumstances?

One could go on and on—what, for example, is the effect of pregnancy on precipitating or even causing thyrotoxicosis? These and other questions will be discussed and answered as far as current knowledge permits.

4:30

### "CHRONIC DISEASE, A CHALLENGE TO THE MEDICAL PROFESSION"

OTIS ANDERSON, M.D., Washington, D. C.

*Assistant Surgeon General and Chief of the Bureau of State Services, U. S. Public Health Service*

The medical profession has been profoundly influenced by the tremendous strides that have been made during the past half century in scientific research in its broadest sense. In a rapidly changing environment it is difficult to assess the respective roles of all who must contribute to today's health needs. Each must be appraised if we are to chart a true course ahead.

We must recognize the difference between the major health problems with which we are now confronted and those which concerned us but a few years ago.

The acute illnesses have been replaced by chronic illness and disability as the major health problem of the Nation. This transition is due largely to the progress that has been made in improved preventive health practices, both clinical and public health.

This shift has profound implications for the medical and other health professions. The division between preventive, curative, and restorative services is difficult to define. These services extend into the socio-economic fields.

Prevention to the extent possible, both with regard to occurrence and progression of chronic disease, is inherent in the basic approach to the problem. We may legitimately question the full utilization of knowledge available to us today in accomplishing the above objectives.

Organized community planning becomes important to the recognition and full use of existing community services and development of other necessary services to supplement and assist the practicing physician in the care of his patient. Our traditional practice of each specialist working more or less independently needs objective scrutiny—no doubt modification.

5:00

### END OF SECOND ASSEMBLY

JULY, 1956

## — Program of Sections —

### WEDNESDAY AFTERNOON

September 26, 1956

#### SECTION ON GENERAL PRACTICE

Meeting—5:00 to 6:00 p.m.—English Room

Reception: 6:00 p.m.—Book Casino

Dinner—7:00 p.m.—English Room

Chairman: J. E. WENTWORTH, M.D., Flint

Secretary: F. P. RHODES, M.D., Detroit

#### "OFFICE MANAGEMENT OF DIABETES MELLITUS"

PERRY S. MACNEAL, M.D., Philadelphia, Pennsylvania

An attempt at good chemical control of every patient with diabetes mellitus should be made with great care, both on the part of the physician and the patient in an effort to minimize the occurrence of the untoward late complications of this disease. The objects of satisfactory control of the diabetic patient are:

1. Maintenance of normal body weight
2. Maintenance of normal blood sugars
3. Avoidance of glycosuria
4. Avoidance of ketonuria
5. Avoidance of hypoglycemia
6. Reasonable adjustments to the requirements of the patient's way of life.

Not all of these goals can be achieved in every case since, in certain severe unstable cases, compromises may have to be made in the interests of practicability. The majority of the patients with diabetes mellitus (that large group of patients who are overweight and who do not lose weight under the influence of their diabetes alone) can be satisfactorily managed without insulin by the simple expedient of reducing their weight to normal by dietary means. Those patients who require insulin (children with diabetes, adults who are underweight at the time they develop diabetes, adults who have lost weight below their ideal standard body weight under the influence of their diabetes alone) can be satisfactorily controlled in almost all instances by appropriate management of the diet, both in reference to its total content and its division and spacing throughout the day. The availability of insulins with different timing of activity makes this goal more likely of achievement. Simple procedures for the office management of the patient with diabetes will be discussed in detail.

#### SECTION ON OBSTETRICS AND GYNECOLOGY

Meeting—5:00 to 6:00 p.m.—Sheraton Room

Chairman: H. B. RICE, M.D., Detroit

Secretary: J. H. BEATON, M.D., Grand Rapids

#### "DIABETES AND PREGNANCY"

EDWIN J. DeCOSTA, M.D., Chicago, Illinois.

In considering the management of the pregnant diabetic patient, we must be guided by certain general principles. Diabetes is a serious medical problem which requires good medical judgment and care. The pregnancy requires good obstetrical judgment and care. Frequently the care of these patients will fall to two or more physicians, the internist, the obstetrician, and the pediatrician, who work closely together. It must be emphasized, however, that while such a team is desirable, it is not a necessity.

The presence of diabetes should not interdict pregnancy unless the diabetes is associated with advanced vascular changes and kidney damage. In spite of efficient care, experience indicates that problems may arise which are somewhat proportional to the severity and duration of the disease and the co-operation of the patient.

Whether or not hormonal therapy is indicated is still a debatable question. But assuming that its most

## PROGRAM

important indication lies in brittle juvenile diabetes, it seems unwarranted to advocate the general use of hormones for all diabetic patients since severe diabetes is rarely encountered. In addition, the cost of such therapy makes its application practically prohibitive. The use of hormones in the management of the diabetic patient therefore is not advocated nor has experience indicated any necessity for its use.

Our policy involves careful management, aiming to maintain the patient so that there will be no symptoms of diabetes, weight gain will be normal, the patient will feel well, and acidosis, coma and insulin reaction will rarely occur. If these conditions are met, there is no objection to the patient passing moderate amounts of sugar. Hospitalization is necessary only with refractory diabetes, for the treatment of complications, and for preparation prior to delivery. Insulin, either long-acting or regular, is given as indicated.

It is believed that the gestation should be terminated when the baby weighs approximately 3500 grams. This weight is often reached in the diabetic patient by the thirty-sixth to thirty-seventh week of gestation. The actual method of terminating the pregnancy will vary with the conditions encountered at that time. Cesarean section is frequently employed, particularly where the cervix is long and closed and the presenting part high.

In spite of the best of care, abortion, hydramnios, fetal oversize, prenatal and neonatal death, and toxemia of pregnancy will occur more frequently in the diabetic patient.

With the delivery of the baby, problems still exist. Although often large, the baby is not necessarily robust. It is essential to maintain clear respiratory passages, to keep the baby warm, to provide an adequate amount of oxygen, and to administer small amounts of glucose solution or dilute milk at frequent intervals.

## SECTION ON OCCUPATIONAL HEALTH

Meeting—5:00 to 6:00 p.m.—Room 907

Dinner—6:30 p.m.—Room 907

Chairman: C. D. SELBY, M.D., Port Huron

Secretary: O. J. JOHNSON, M.D., Bay City

### "CURRENT TRENDS IN OCCUPATIONAL HEALTH"

SEWARD E. MILLER, M.D., Washington, D. C.

The changing character and scope of industrial health programs have been largely dictated by the prevailing social concepts of industry's role and responsibility for worker health. Thus, the early industrial health services were primarily based upon medical care for industrial illness and injuries and the prevention of accidents and occupational diseases. As industry has come to recognize the importance of conserving the total health of the worker to keep him on the job, industrial health services are becoming increasingly oriented to the early detection and prevention of all diseases—not only those related to the occupation. The need for broad preventive services and health maintenance programs is being accentuated by the advancing age level of the working population and the rising incidence of chronic and degenerative diseases.

Recently, there has been a growing trend to utilize more fully the opportunity afforded by the preplacement and the periodic health examinations for promoting and maintaining the health of the worker. This is achieved not only through the early detection of incipient developing disabilities, but also by helping the worker solve his health and emotional problems through health education, counseling, and appropriate utilization of community and social resources. Corollary to this trend, there has been a move toward special education and training in health maintenance and occupational diseases for industrial physicians and nurses with emphasis on the preventive aspects.

Another development in the industrial health field which holds great promise is the variety of efforts being carried on to find ways and means of providing health services to workers in small plants. Such services are still not available to about 70 per cent of our working population. How to economically and effectively bring medical and nursing services to the workers in small establishments represents one of the greatest present challenges in the field of occupational health. To date, three general types of industrial health programs for small plants have evolved: (1) community-sponsored programs, (2) co-operative programs, and (3) individual programs.

With the increasing emphasis on nonoccupational health measures, however, care must be taken to avoid complacency toward the safety and industrial hygiene aspects of industrial preventive health services. New

materials and processes are being introduced daily into industrial establishments. Physicians and nurses must know the health hazards involved and work closely with the industrial hygienist to carry out their joint responsibility in protecting the worker's health.

## SECTION ON PEDIATRICS

Meeting—5:00 to 6:00 p.m.—Pan American Room

Dinner—6:30 p.m.—Pan American Room

Chairman: BERNARD BERNBAUM, M.D., Detroit

Secretary: C. E. BOOHER, M.D., Grand Rapids

### "PREDISLOCATION PHASE OF CONGENITAL DISLOCATION OF THE HIP"

JOHN P. CAFFEY, M.D., New York, New York

The current preventive practices for congenital dislocation of the hip, use of the Frejka pillow splint and the Hass bar, are based on the hypothesis that the predislocation phase can be identified radiographically by the demonstration of high acetabular angles in combination with limitation of abduction and external rotation. The size of the acetabular angles, measured radiographically in 1500 unselected newborns will be presented with follow-up radiographic measurements in the same infants at six months and twelve months of age. These findings indicate a wide variation in the size of the acetabular angles in healthy infants; approximately 50 per cent of white girl infants show angles greater than 29 degrees, the value which has been widely used as the upper limit of normal. The findings in this group, by far the largest unselected infant population tested for size of the acetabular angles, demonstrate that the predislocation phase of congenital dislocation of the hip is being diagnosed too frequently and unnecessary preventive measures are being applied to healthy infants, in large numbers.

## SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE

Meeting—5:00 to 6:00 p.m.—Room 807

Dinner—6:30 p.m.—Room 807

Chairman: V. K. VOLK, M.D., Saginaw

Secretary: J. D. MONROE, M.D., Pontiac

### "CHRONIC DISEASE, A CHALLENGE TO PUBLIC HEALTH"

OTIS ANDERSON, M.D., Washington, D. C.

Improvement in the general health of the Nation's population and the increased longevity associated with it are responsible for the transition which public health practice has been undergoing during recent years.

Of importance today, is the recognition that chronic disease—frequently causing long-term illness and disability—represents a major health problem. Admittedly, much research needs to be done to further the progress of community application of chronic disease control practices. However, within the limits of our present knowledge, there is still much that can be done.

Positive community action will be required to supply the wide range of services necessary to prevent the occurrence or progression of chronic disease and disability.

The public health agency has a vital role in bringing together all forces of the community which can contribute to these services, in providing leadership in planning for their best utilization, and in furnishing some of the services needed. Services for the private physician must be supported by those of the laboratory, the hospital, the rehabilitation facility, and a number of related services. Nursing care is needed in the hospital and in the home. Physical therapy, nutritional advice, and medical social services must be arranged for. Many of these special services can be provided by the health department. Others can more appropriately be arranged for from other sources. In either event, active participation by the public health team will be called for.

State and local health departments should include in their planning a study of this problem and how they can best make their contribution.

# PROGRAM

## SECTION OF UROLOGY

Meeting—5:00 to 6:00 p.m.—Parlors G and H

Dinner—6:30 p.m.—Parlors G and H

Chairman: J. F. HARROLD, M.D., Lansing

Secretary: H. V. MORLEY, M.D., Detroit

### "RETROPUBIC RADICAL PROSTATECTOMY FOR CANCER"

JOHN K. LATTIMER, M.D., New York, New York

The retropubic (or suprapubic) radical prostatectomy can be easily accomplished by any surgeon versed in this approach to the Prostate. The incidence of post-operative incontinence may be lower than from perineal radical prostatectomy. Radical removal of the early carcinoma of the prostate is the only curative maneuver presently available in the treatment of this disease. Technical means of making the operation easier will be shown in lantern slides and in a motion picture of the operation.

## WEDNESDAY EVENING

September 26, 1956

### Officer's Night

Grand Ballroom, Sheraton-Cadillac Hotel

President: W. S. JONES, M.D., Menominee

Secretary: L. FERNALD FOSTER, M.D., Bay City

P.M.

6:30 Officers' Night Reception

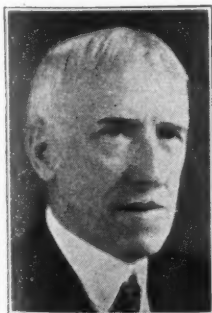
7:15 Officers' Night Banquet, honoring Officers of the Michigan State Medical Society and its Woman's Auxiliary (Informal)

8:30 1. Announcements and reports of the House of Delegates by L. Fernald Foster, M.D., Secretary

2. Induction of New Officers

3. President's Annual Address by W. S. Jones, M.D.

4. The Andrew P. Biddle Lecture



ANDREW P. BIDDLE, M.D.

(Deceased August 2, 1944)

Patron of Postgraduate Medical Education

5. Presentation of Biddle Lecture Scroll

10:00 6. Adjournment

JULY, 1956

## THURSDAY MORNING

September 27, 1956

### Third Assembly

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: E. T. THIEME, M.D., Ann Arbor

Secretary: C. H. WARD, M.D., Detroit

A.M.

9:00

### Surgery Panel on "THYROID DISEASES"

Moderator: FREDERICK A. COLLIER, M.D., Ann Arbor

Professor of Surgery and Chairman of the Department, University of Michigan

Participants:

DWIGHT E. CLARK, M.D., Chicago, Illinois

Professor of Surgery; Senior Attending Surgeon, Albert Merritt Bellings, Hospital of the University of Chicago Clinics; Secretary, Department of Surgery

E. PERRY McCULLAGH, M.D., Cleveland, Ohio

Head of Department of Endocrinology and Metabolism, Cleveland Clinic

JAMES H. MEANS, M.D., Boston, Massachusetts

Physician, Massachusetts Institute of Technology; Jackson Professor of Clinical Medicine, Harvard; Emeritus Honorary Physician, Massachusetts General Hospital

10:00

### INTERMISSION TO VIEW EXHIBITS

11:00

### "INDICATIONS FOR TRACHEOTOMY"

G. SLAUGHTER FITZ-HUGH, M.D., Charlottesville, Virginia

Professor and Chairman, Department of Otolaryngology, School of Medicine, University of Virginia; Otolaryngologist-in-Chief, University of Virginia Hospital

The author has been following the trends in the use of and indications for tracheotomy, under various conditions, since 1940. Initially, the procedure was performed, in the vast majority of instances, for the relief of obstruction in the upper respiratory tract at the laryngeal level. In this earlier group of cases, a high percentage (40 per cent) were performed in patients of two years and younger.

In the succeeding interim and particularly in recent years, the indications for tracheotomy have broadened in scope tremendously. Much of the impetus to this increase in indications has been secondary to the work of Galloway, Priest, Bower, Cummings, and others, in their studies of the respiratory problems of poliomyelitis.

One now recognizes the value of tracheotomy in relieving, less dramatically, respiratory distress and complications following abolition of the cough mechanism and the resulting accumulation of fluid in the lower respiratory tract. Emphasis in this particular presentation is placed on the physiologic disturbances which will be detrimental to the patient as the result of this type of obstruction in the respiratory tract.

The number of patients in this lower respiratory obstruction group, having tracheotomy, are now, in our experience, in the majority, and, as one would expect, are predominantly adults.

It behooves all practicing physicians in any phase of medicine to be aware of the value of tracheotomy or the alternative methods of preventing and relieving the accumulation of fluid in the tracheobronchial tree.

Brief observations are made in regard to the contraindications to, complications of, and substitutes for tracheotomy.

The following classification is utilized in presenting the indications for tracheotomy.

1. Fixed obstruction to the upper airway. (Rapid obvious anoxia).
2. Fluid obstruction to lower airway. (Slow obscure anoxia).
3. Prophylactic. (To prevent 1 and/or 2.)
4. Spasm (*per se*—questionable indication).

# PROGRAM

## 11:30 "THE CYSTIC OVARY—SURGICAL OR NON-SURGICAL?"

JOHN R. SCHENKEN, M.D., Omaha, Nebraska  
*Pathologist and Director of Laboratories, Nebraska Methodist Hospital and Children's Memorial Hospital, Omaha, Nebraska; Professor and Chairman, Department of Pathology, University of Nebraska College of Medicine, Omaha*

Coe in 1887 commented on the diagnosis of ovarian disease, that "What has been said regarding the variations in size, shape, and external appearance, it may be inferred that there are many opportunities for error." Warnings of this type have been repeatedly recorded by physicians who are interested in ovarian pathology. The purpose of this study was to review some of the problems of the cystic ovary as viewed by the pathologist and to determine whether the differentiation of the diseased from the non-diseased cystic ovary in situ is more skillfully made by a jury of specialists or by a jury of non-specialists.

An analysis was made of 793 diseased ovaries which had been removed surgically. Fifty per cent of these were found to be non-neoplastic, a high percentage of which showed endometriosis. Our chief interest was to discuss the differentiation between neoplastic and non-neoplastic cystic ovary, with general comments as to the outlook in the neoplastic group.

We also studied the effect of an educational program during a six-year period through the medium of medical students, interns, residents, medical staff, and non-euphemistic reporting of normal structures in the ovary. We were gratified to learn from our data that both the specialist and the non-specialist showed sharp improvement in his ability to detect a diseased from a non-diseased cystic ovary, and that in the entire group, only one unnecessary castration was carried out. There was, likewise, an increasing number of instances when only a portion of the ovary was submitted for examination instead of an entire ovary.

We were forced to conclude that the impact of forthright reporting of normal tissues and the sympathetic understanding of the problems involved, on the part of pathologists, were responsible for this improvement in detecting diseased ovarian tissue and this was accomplished without the benefit of the public castigation of the physician through lay publications.

## 12:00 END OF THIRD ASSEMBLY

## THURSDAY NOON September 27, 1956

12:00 noon to 1:00 p.m.

### Discussion Conference

Grand Ballroom, Sheraton-Cadillac Hotel

**Leader:** FREDERICK A. COLLIER, M.D., Ann Arbor

**Participants:** DWIGHT E. CLARK, M.D., Chicago, Illinois; RICHARD C. CONNELLY, M.D., Detroit, Michigan; G. SLAUGHTER FITZ-HUGH M.D., Charlottesville, Virginia; JOHN W. HENDERSON, M.D., Ann Arbor Michigan; M. RALPH KAUFMAN, M.D., New York, New York; ALFRED M. LARGE, M.D., Detroit, Michigan; E. PERRY McCULLAGH, M.D., Cleveland, Ohio; JAMES H. MEANS, M.D., Boston, Massachusetts; H. MARVIN POLLARD, M.D., Ann Arbor, Michigan; JOHN R. SCHENKEN, M.D., Omaha, Nebraska; LEON SCHIFF, M.D., Cincinnati, Ohio; THEODORE F. SCHLAEGEL, Jr., M.D., Indianapolis, Indiana; and WARREN E. WHEELER, M.D., Columbus, Ohio

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## THURSDAY AFTERNOON

September 27, 1956

### Fourth Assembly

Grand Ballroom, Sheraton-Cadillac Hotel

**Chairman:** R. C. CONNELLY, M.D., Detroit  
**Secretary:** WADSWORTH WARREN, M.D., Detroit

P.M.  
2:00

## WILLIAM BEAUMONT, M.D. LECTURE (Sponsored by the Michigan Foundation for Medical and Health Education, Inc.) "CLUES AND PITFALLS IN THE DIAGNOSIS OF JAUNDICE"

LEON SCHIFF, M.D., Cincinnati, Ohio

*Professor of Clinical Medicine, University of Cincinnati Medical School; Director, Gastric Laboratory, Cincinnati General Hospital*

Valuable clues in the diagnosis of the cause of jaundice are the age of the patient, history of exposure to known hepatotoxic agents, history of alcoholism, history of previous biliary tract surgery or resection of a malignant tumor, the presence of splenomegaly, a typical laboratory "profile" of obstructive jaundice, x-ray findings of gall stones or peri-ampullary tumor, et cetera.

Paradoxically, these clues may of themselves occasionally prove misleading. In addition constitutional hepatic dysfunction may be mistaken for hepatitis, intra-hepatic cholestasis for extra hepatic obstruction, infectious mononucleosis for infectious hepatitis, etc. Numerous examples will be given and the means of avoiding some of these pitfalls pointed out.

## 2:30 "THE ETIOLOGY AND DIAGNOSIS OF ENDOGENOUS UVEITIS"

THEODORE F. SCHLAEGEL, JR., M.D., Indianapolis, Indiana

*Assistant Professor of Ophthalmology, Indiana University Medical Center; Director of Research, Department of Ophthalmology, Indiana University Medical Center*

Ophthalmologists and other physicians have been repeatedly frustrated over the years by attempts to find foci of infection and other signs of disease in patients with uveitis. These frustrations have led to doubts as to the value of a general physical check up in uveitis patients. Although there is strong evidence that various bacteria and parasites are important agents in the production of uveitis, preliminary studies have indicated that uveitis may also be a stress disease.

So far we have correlated two main types of stress with the onset of uveitis. These two factors which seem to be active in precipitating attacks of uveitis are fatigue and increased responsibility. The patient may be fatigued from working at two jobs, getting drunk every night, or by continuing to work when debilitated by virus pneumonia.

Increased responsibility has been observed in many forms. In 3 of a series of 12 patients it consisted of the extra load of buying a new home. Other patients are plagued by increased responsibility in the form of a promotion on the job, the invasion of one's home by the extra mouths of hungry relatives, or by the coming of a new baby to add weight to responsibilities already too heavy to bear.

In our experience the ferreting out of such factors as fatigue and increased responsibility and their proper handling may be of more value than many of the standard procedures. One patient failed to improve from any type of therapy but did improve as soon as he was changed to a less responsible position. The physician should insist that the uveitis patient be absolved from all duties he can shed and should see to it that the patient receives adequate rest, both mentally and physically. It is of value for the physician to temporarily "mother" or "baby" the patient, hospitalization is especially recommended for then the patient can feel free to shed his cares and regress.

## 3:00 INTERMISSION TO VIEW EXHIBITS

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# PROGRAM

## 4:00 "BACTERIAL DISEASE IN THE NEW-BORN"

WARREN E. WHEELER, M.D., Columbus, Ohio

*Professor of Pediatrics and Bacteriology, Ohio State University*

The two most important epidemic diseases of newborn infants are impetigo and epidemic diarrhea of the newborn. Both of these are caused by strains of common bacteria, *Staphylococcus aureus* and *Escherichia coli* (colon bacillus) respectively. These bacteria are ubiquitous in the environment and are harbored by normal healthy adults. Meticulous aseptic nursery technique can be relied upon to minimize the transfer of these organisms to newborn babies and perhaps to delay the colonization of the infants by them. However, it is normal for tiny babies to acquire staphylococci on the skin and in the nose and throat and *E. coli* on the skin and in the intestines.

Fortunately, only rare strains of these organisms produce manifest disease in infants. Such strains are endowed with special properties of invasion and pathogenicity so that when an infant is colonized disease may be produced—if not immediately, then some time later when the baby's resistance has been reduced by some unrelated incident.

Recent experience emphasizes that these pathogenic strains are widespread in their distribution. Epidemiologic studies with such strains, especially staphylococci, have brought forth new concepts of the usual pathways of transmission of such organisms and measures necessary to control their spread. These newer concepts will form the basis of the presentation.

## 4:30 "PSYCHOTHERAPIES IN A GENERAL HOSPITAL"

M. RALPH KAUFMAN, M.D., New York, New York

*Psychiatrist to the Hospital; Director, Department of Psychiatry, The Mount Sinai Hospital; Clinical Professor of Psychiatry, P&S, Columbia University; President, Medical Board of Mount Sinai Hospital and Chairman of its Committee on Medical Education*

Psychotherapy in various forms is inherent in the art of the practice of medicine. The understanding and utilization of the patient-physician relationship is of paramount importance. This fact has implications for the training of the medical student, intern, and resident. Psychiatry in this sense has become a basic science in the same way as physiology. Psychotherapy in its various forms, however, is a technical instrument, and therefore there can be no profession of psychotherapist as such, since a profession must have within itself the full potential for the management of all the varied problems that arise in its practice.

The treatment of patients involves a continuing diagnostic acumen with the necessary flexibility for whatever treatment emphasis becomes necessary at any given time. Such continuing responsibility for a patient can only be the responsibility of a physician. A split between psyche and soma runs contrary to all present day concepts of the integration and function of the organism that is the patient. This is true even though the practice of medicine at the present time is divided into major areas of specialization. Nevertheless, each practitioner in addition to the special training and skills in a particular area still has the total responsibility for the individual. This responsibility may be discharged in many ways including the collaborative working with other members of the medical profession and adjuvant professions. The psychiatrist as a member of the medical profession has developed refinements of diagnosis and therapeutic skills which makes him the elective physician for certain types of problems which fall within the range of the specialty of psychiatry.

The paper deals with the kind of psychotherapeutic opportunities and practices that are available to a psychiatrist functioning within the framework of a general hospital, both in relation to patients who are directly in his charge and, collaboratively, with patients of other physicians functioning in the hospital.

## 5:00 END OF FOURTH ASSEMBLY

## —Program of Sections—

### THURSDAY AFTERNOON

September 27, 1956

#### SECTION ON GASTROENTEROLOGY AND PROCTOLOGY

Meeting—5:00 to 6:00 p.m.—English Room

Reception and Dinner—6:30 p.m.—Statler Hotel

*Chairman:* R. C. CONNELLY, M.D., Detroit

*Secretary:* NORMAN D. NIGRO, M.D., Detroit

#### PANEL ON "MEDICAL AND SURGICAL PROBLEMS OF LIVER DISEASE"

*Moderator:* RICHARD C. CONNELLY, M.D., Detroit, Michigan

*Clinical Associate Professor of Medicine, Wayne University College of Medicine; Attending Physician, Harper and Bon Secours Hospitals*

LEON SCHIFF, M.D., Cincinnati, Ohio

H. MARVIN POLLARD, M.D., Ann Arbor

*Professor of Internal Medicine, University of Michigan Medical School*

ALFRED M. LARGE, M.D., Detroit

*Assistant Professor of Clinical Surgery, Wayne University College of Medicine; In Charge of the University Surgical Service, Grace Hospital, Detroit; Surgical Consultant, Dearborn Veterans Administration Hospital and U.S.P.H.S. Hospital, Windmill Point, Michigan; Attending Surgeon, Bon Secours Hospital, St. John Hospital; Associate Surgeon, Detroit Receiving Hospital.*

#### SECTION ON NERVOUS AND MENTAL DISEASES

Meeting—5:00 to 6:00 p.m.—Pan American Room

Dinner—6:30 p.m.—Pan American Room

*Chairman:* C. H. WARD, M.D., Detroit

*Secretary:* R. W. CAVELL, M.D., Ann Arbor

#### "THE PROBLEM OF PSYCHIATRIC SYMPTOM FORMATION"

M. RALPH KAUFMAN, M.D., New York City

The problem of psychiatric symptom formation will be presented from a point of view which will attempt to relate psychic symptoms and signs within the general framework of medicine. Scientific medicine is firmly based on a biological orientation. Psychiatry is a branch of medicine. Therefore, any attempt to understand psychiatric symptom formation must relate essentially to the understanding of the symptom formation in any of the other areas of medicine. Since there are fundamental biological laws, any explanation of symptom formation regardless of the nature of the symptom must be within the sphere of biology. Therefore, from this point of view, fever and phobia must qualitatively serve a similar biological function in relation to the adaptation of the organism.

Particular emphasis will be placed on the contribution of psychoanalysis to this problem.

#### SECTION ON OPHTHALMOLOGY

Meeting—5:00 to 6:00 p.m.—Sheraton Room

Dinner—6:30 p.m.—Sheraton Room

*Chairman:* C. W. LEPARD, M.D., Detroit

*Secretary:* B. C. WILDGEN, M.D., Muskegon

#### "THE DIAGNOSIS OF FUNCTIONAL VISUAL FIELD DEFECTS"

THEODORE F. SCHLAEGEL, JR., M.D., Indianapolis, Indiana

Visual fields studies should be started on a tangent screen and carried out in a clockwise or counter-clockwise manner and not by the checking of opposite ends

## PROGRAM

of a single diameter or by the checking of various areas in a random fashion. It is necessary to use such a clockwise or counter-clockwise technique to demonstrate spiral fields when they are present. Such fields will spiral down towards the fixation point as one proceeds around the tangent screen in either direction.

The tubular fields of hysteria are diagnosed easily from the following criteria:

1. The fields are the same size no matter what the distance.
2. The borders are very sharp no matter what the size of test object.
3. The field is circular in shape.

In my experience tubular fields are usually about 1 foot in diameter or about the size of the 10 degree circle at one meter. If the fields are not contracted, they are not tubular. If they are contracted, one should test with a larger test object such as an 8 by 12 inch sheet of paper. If the fields remain contracted to the same circle on the tangent screen with this large test object, the patient should be moved back to two meters and rechecked. If the size of the field remains at the same place on the tangent screen, the diagnosis of tubular fields of hysteria is clinched.

Other hysterical visual field defects such as hysterical hemianopsia and hysterical central scotoma may be diagnosed by use of the first two criteria mentioned. These hysterical defects will be of the same size no matter what the distance and the borders will be sharp no matter what the size of test object.

### SECTION ON OTOLARYNGOLOGY

Meeting—5:00 to 6:00 p.m.—Parlors G and H

*Chairman:* WADSWORTH WARREN, M.D., Detroit

*Secretary:* J. M. LEBERGE, M.D., Wyandotte

#### "TEMPORAL BONE SURGERY: A SURVEY AFTER THE ADVENT OF THE MANY ANTIBACTERIAL AGENTS"

G. SLAUGHTER FITZ-HUGH, M.D., Charlottesville, Virginia

A survey of the quantity and types of temporal bone surgery, performed in a relatively small general hospital (University of Virginia) since the availability of the many successful antibacterial agents, has been made. In the analysis of groups of such surveys from various areas throughout the country, one may obtain interesting data in regard to the trends in Otolaryngology, the material available for training residents, and possibly some ideas as to the demands for otologists in the major surgical field.

As all are aware, there has been a tremendous decrease in the necessity for temporal bone surgery as the result of bacterial infection or suppurative ear disease. However, in turn there has been an increase in temporal bone surgery for non-suppurative conditions, with the hope of restoring hearing, improving balance and facial movements, and controlling neoplasms. That this increase is proportional or more than proportional, as has been noted in certain areas, can be determined only by surveys such as the one presented.

One fact seems certain, that even though the number of dangers, resulting from otological infections requiring surgery, has markedly diminished, they are still ever present and serious. Some one must be available to cope with the various surgical conditions. Also, with the release of the otologist's time from the care of the infections, this has in turn provided him with time for the development of surgical technique beneficial to non-infectious, pathological conditions so plaguing to the population, such as deafness, tinnitus, vertigo, and so forth.

#### "ETIOLOGY OF POST-MENOPAUSAL BLEEDING—A SURVEY BASED UPON AN ANALYSIS OF PATHOLOGIC LESIONS FOUND IN THE GENITAL TRACT"

JOHN R. SCHENKEN, M.D., Omaha, Nebraska

Practically all surveys on the subject of post-menopausal uterovaginal bleeding which have been reported in the literature have been based on the analyses of the findings as revealed from a clinical approach through office, clinic, and hospital material.

This analysis was based on the examination of 300 consecutively received specimens which were from women over 55 years of age, and which presented one

or more pathologic lesions which could or did produce bleeding. This type of survey excludes all problems of bleeding caused by blood dyscrasias, ovarian tumors, and the like.

We found that 30% of these specimens revealed a malignant tumor as the cause of the bleeding. This is in contrast to the wide variations from about 16 to 87% which has been reported in the literature. Each of the surveys in the literature is subject to special interpretation since those that are made from private practice generally show a much lower incidence of malignancy than those from a free charity clinic which show a much higher incidence, despite the fact that the medical service is free. The results of our survey emphasize the fact that the major cause of post-menopausal bleeding is not malignancy, and that every effort should be made to establish the etiology before hysterectomy or radium implantation is carried out. Our survey also revealed the fact that there were many instances of co-existing multiple lesions, each of which was capable of producing bleeding. Hence, the simple removal of an endocervical polyp or the like cannot be justified without the investigation of the possible more serious source of hemorrhage in the uterine cavity.

### SECTION ON SURGERY

Meeting—5:00 to 6:00 p.m.—Grand Ballroom

*Chairman:* E. T. THIEME, M.D., Ann Arbor

*Secretary:* H. M. BISHOP, M.D., Saginaw

#### "THE PROBLEM OF PROGRESSIVE EXOPHTHALMUS IN THYROID DISEASE"

JOHN W. HENDERSON, M.D., Ann Arbor, Michigan

*Associate Professor of Ophthalmology, University of Michigan*

The problem of progressive exophthalmos associated with thyroid disease will be discussed. The current trend is to consider progressive exophthalmos a separate entity with or without associated thyrotoxicosis. The lack of correlation between thyrotropin levels and active proptosis, as well as failure of thyroid medication to uniformly halt the process cast doubt on traditional concepts. Recent reports suggest the possibility of a separate exophthalmos-producing hormone as a causative factor.

## THURSDAY EVENING

September 27, 1956

### State Society Night

Grand Ballroom, Sheraton-Cadillac Hotel

P.M.  
10:30

An evening of entertainment for all registrants, ladies and guests

Cabaret-style Dance and Floor Show

Host: Michigan State Medical Society

(Admission by card furnished to all upon registration)

ONLY ONE MORE DAY TO VISIT YOUR  
MANY FRIENDS IN THE EXHIBIT

## PROGRAM

# FRIDAY MORNING

September 28, 1956

## Fifth Assembly

Grand Ballroom, Sheraton-Cadillac Hotel

Chairman: O. S. HENDREN, M.D., Pontiac

Secretary: H. V. MORLEY, M.D., Detroit

A.M.  
9:00

### "PROLONGED LABOR"

LEROY A. CALKINS, M.D., Kansas City, Kansas

Professor and Chairman of the Department of Obstetrics and Gynecology, University of Kansas Medical School.

The definition of prolonged labor is still to be decided. When labor starts is still disputed. The difference between "false" labor, "prodromal" labor and very early "slow" starts is so minimal that hours of close observation are required in making the only possible differential diagnosis.

The time-honored management of "watchful expectation," ample fluid intake, and indicated sedation and rest periods is still to be recommended. When we are dealing with a normally soft cervix, this treatment can still be confidently advised. If, however, the cervix is firmer than is usual, this method of management can lead to bad results in a surprisingly large percentage of patients.

In order properly to diagnose this firmness of cervix (13 per cent of primigravida and 3 to 4 per cent of multigravida), one must palpate it at the height of a good uterine contraction. This is often impossible early in labor when the contractions are relatively weak or when (as is very frequently true in multigravida) the internal os is undilated but the external os is soft and considerably dilated. In other words, the presenting part must be in contact with the external os, and the examination must be made at the height of a relatively good contraction.

If, under these circumstances, either of these two conditions is existent, (1) the cervix tends to soften as dilation progresses, (2) the uterine contractions tend to increase in frequency and intensity, nothing need be feared.

If, however, the cervix remains firm up to 6 cm. dilation and the uterine contractions remain weak and far apart, a high fetal mortality can be expected. Fortunately, this combination of events is not particularly common but still too frequent for comfort. To determine it requires close and continued observation. Proper management will be discussed.

9:30

### "SOME ASPECTS OF DIAGNOSIS OF LUNG TUMORS AND CANCER"

AVERILL A. LIEBOW, M.D., New Haven, Connecticut

Professor of Pathology, Yale University; Pathologist-in-Chief, Grace-New Haven Community Hospital, University Services

From the standpoint of treatment, the important cancer is the cancer that has not metastasized. Despite occasional notable successes, survey films have been disappointing. The difficulty is that large cancers may be silent. On the contrary, small tumors may produce serious symptoms, but these are often neglected by the patient, or misinterpreted by the physician. It is the responsibility of the general practitioner to bring these lesions to early diagnosis and treatment. Any man over forty-five with symptoms of thoracic disease who has been a heavy smoker should be a suspect. It must be remembered that, with early bronchogenic carcinoma, one sees the result of the tumor rather than the tumor itself in roentgen films. Therefore, specialized radiographical methods such as body section and bronchography, bronchoscopic and cytological methods should be employed without delay.

Among the common symptoms are the appearance, increase, or alteration in character of cough; chest pain or discomfort; expectoration; hemoptysis; dyspnea; evidence of bronchial stenosis or obstruction such as wheezing; or signs of pneumonitis. Among the later manifestations are evidences of involvement of other thoracic structures, such as vocal cord paralysis, Horner's syndrome, superior caval obstruction, or dysphagia. The appearance of metastatic tumor in

distant organs or tissues may, unfortunately, precede the signs of the disease in the chest.

A simple classification may be made according to predominant cell type:

- A. Bronchogenic carcinoma
  1. Epidermoid carcinoma
  2. Anaplastic carcinoma
  3. Adeno carcinoma
  4. Mixed type
- B. Bronchiolar carcinoma ("Pulmonary Adenomatosis," "Alveolar cell carcinoma.")

Epidermoid carcinoma accounts for between 45 per cent and 60 per cent of all bronchogenic tumors and tends to predominate in the male in the ratio variously stated as 10:1 to 20:1. The peak age incidence is at sixty, later than that of other bronchogenic cancers. There is radiographic evidence that some, at least, may develop very slowly, over four or five years. Most of these tumors involve major bronchi, in bulk, but some are largely mucosal in position, resembling granulation tissue. Both types often are associated with a pneumonitis, or bronchiectasis distally that accounts for much of the symptomatology. Many bronchogenic epidermoid tumors cavitate but can often be distinguished from true abscess by the absence of an appropriate history, in the relatively old age group involved, in the fact that they do not necessarily lie in the "path of aspiration," in their relatively thick irregular walls, and notched outlines. Some of these tumors occur peripherally: A lung tumor that invades the body wall is more likely to be a well differentiated squamous cell tumor than any other type. Spread to lymph nodes usually occurs slowly, at first by direct invasion. Hematogenous metastases are late, but may be widespread when pulmonary veins are involved.

Anaplastic carcinoma: Among the anaplastic tumors are the so-called oatcell tumors, but others are more differentiated and tend to approach the epidermoid type. Male predominance is even higher, but relatively more occur below the age of 40. Most of these tumors involve the stem or lobar bronchi. They quickly involve nodes so that the hilar mass becomes continuous with the mediastinal metastases, and there is also extension peripherally in "sunburst" arrangement. Hematogenous metastases are also frequent and may constitute the first clinical sign of the disease. Necrosis is rarely sufficient to result in radiographically demonstrable cavitation.

Adenocarcinoma: Approximately 15 per cent of bronchogenic carcinomas are of mucus producing glandular type. Although still predominantly a disease of the male, this tumor is the most common type in women. Although most of these lesions are hilar, relatively more occur peripherally than with the other histological types. When cavities occur, they tend to be small. Growth is relatively rapid as compared with squamous carcinoma and metastases tend to be widespread, involving chiefly the blood stream, although lymphatic pathways are not neglected.

Bronchiolar carcinoma: These are very peripherally situated lesions, not associated with any major bronchi, having a varying structure, often observed within the confines of the same tumor, from very well differentiated to definitely adenocarcinomatous structure. Grossly, two main varieties exist, a multi-nodular form resembling metastatic tumor, and a pneumonia-like, vaguely outlined form, occurring singly or in the form of scattered lesions. This lesion often develops almost asymptotically, although it may follow what seems to be a pneumonic episode. Although abundant mucoid sputum is characteristic, this actually occurs relatively uncommonly. Many of these lesions are entirely silent clinically, and are detected only by routine radiographic examination. If sputum exists, cytological examination is very helpful in establishing a diagnosis. When the lesion occurs as a single focus considerable success has been attained in treatment, even by lobectomy. Many, however, tend to spread, largely by lymphatics, but also perhaps by transbronchial aspiration to other foci within the lung. Most patients die of replacement of pulmonary substance by neoplastic tissue. Approximately 50 per cent of these tumors remain confined within the thorax, without metastasis elsewhere. Others metastasize widely.

Until methods of curative radiotherapy or chemotherapy are discovered, it would seem best to treat the bronchogenic carcinomas as radically as compatible with sufficient residual pulmonary function. The value of prophylactic resection of draining lymph nodes in the mediastinum *en bloc* with the primary tumor has not been established, although suggested. Transection of veins intrapericardially, and the inclusion of the pulmonary ligament in the resection is probably desirable in view of the close relationship of the bronchi and nodes to these structures.

10:00

### INTERMISSION TO VIEW EXHIBITS

July, 1956

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## PROGRAM

### 11:00 "THE ART OF TOPICAL THERAPY"

HERBERT S. RATTNER, M.D., Chicago, Illinois

*Professor and Chairman, Department of Dermatology, Northwestern University; Chief Editor, AMA Archives of Dermatology*

*The Art of Topical Therapy* will consider when, where and why to use the various topical agents such as wet dressings, shake lotions, ointments, pastes, etc.; which drugs to use under these different circumstances; and an appraisal of the various topical steroid preparations that are available on the market. Exemplary lantern slides will be presented.

### 11:30 "MILKERS' NODULES"

EDWARD P. CAWLEY, M.D., Charlottesville, Virginia

*Professor and Chairman, Department of Dermatology, University of Virginia School of Medicine*

Milkers' nodules is an unique disease characterized by the appearance of inflammatory nodules on the exposed skin of persons who milk cows. The disorder in humans has been reported from six states in the U.S.A. (Iowa, Delaware, Virginia, Tennessee, Louisiana and Minnesota) and has been encountered in at least two more states (Michigan and Wisconsin) from which formal reports have not been made. There is reason to believe that the geographic distribution is more widespread than these data would indicate, and that the disease is far from rare.

Milkers' nodules sometimes occurs in epidemic form in large herds of milk cows. A few animals are involved at a given time and the disease passes slowly through the herd until it finally dies out. Milkers' nodules also appears in sporadic outbreaks on farms where a single cow or a small herd is kept. The disease in the cow is characterized by several lesions on the teats and udders, but the cow is not systemically ill.

Milkers' nodules in humans is a self limited, inflammatory cutaneous lesion (or lesions) which goes through macular, papular, vesicular and crusted stages and heals without scar formation in from four to eight weeks. The uncomplicated disease is productive of few local symptoms and the patient shows no evidence of systemic involvement.

Attempts to transmit milkers' nodules to experimental animals using material from lesions on humans or cows have resulted in failure but a number of clinical and epidemiological features suggest that milkers' nodules is an infectious disease with a low degree of infectiousness and a high degree of dermatotropism.

Various features of milkers' nodules, including epidemiology, clinical aspects, pathology and treatment will be described.

### 12:00 END OF FIFTH ASSEMBLY

## FRIDAY NOON

September 28, 1956

12:00 noon to 1:00 p.m.

### Discussion Conference

Grand Ballroom, Sheraton-Cadillac Hotel

*Leader:* HAROLD HENDERSON, M.D., Detroit

*Participants:* KENNETH E. APPEL, M.D., Ardmore, Pennsylvania; EDWARD P. CAWLEY, M.D., Charlottesville, Virginia; LEROY A. CALKINS, M.D., Kansas City, Kansas; JACK M. KAUFMAN, M.D., Detroit, Michigan; AVERILL A. LIEBOW, M.D., New Haven, Connecticut; GEORGE R. MENEELY, M.D., Nashville, Tennessee; JOHN M. MURPHY, M.D., Detroit, Michigan; O. SIDNEY ORTH, M.D., Madison, Wisconsin; CHARLES A. POINDEXTER, M.D., New York, New York; MYRON PRINZMETAL, M.D., Beverly Hills, California; and HERBERT S. RATTNER, M.D., Chicago, Illinois

## FRIDAY AFTERNOON

September 28, 1956

### Sixth Assembly

Grand Ballroom, Sheraton-Cadillac Hotel

*Chairman:* E. O. PEARSON, M.D., Kalamazoo

*Secretary:* B. B. BLUM, M.D., Petoskey

P.M.

2:00

### "MEDICAL AND PSYCHIATRIC COLLABORATION—IMPORTANCE AND POSSIBILITY"

KENNETH E. APPEL, M.D., Ardmore, Pennsylvania

*Professor of Psychiatry, Chairman of the Department, School of Medicine, University of Pennsylvania*

*The Concepts of Mental Health and Mental Illness*

What is mental health? Not merely the absence of nervousness, tension, anxiety, discouragement and guilt.

What is mental illness? Not just the absence of health.

The importance of mental illness for the physician and the community.

The general practitioner, internist, surgeon, pediatrician are necessary in psychiatry. At times they have been of more help than the psychiatrist.

Ways of collaboration. Opportunities for the non-psychiatrist in the treatment of mental illness and preservation of mental health.

KENNETH E. APPEL, M.D.

*Professor of Psychiatry and Chairman of the Department, University of Pennsylvania*

2:30

### "PHYSICIAN ALERTNESS TO ALTERED PHYSIOLOGY DURING ANESTHETIZATION"

O. SIDNEY ORTH, M.D., Madison, Wisconsin

*Professor and Chairman, Department of Anesthesiology, University of Wisconsin Medical School*

All drugs used to produce anesthesia (local or general agents) are toxic! The very nature of the actions desired in their use is evidence of this fact. In the course of the desired actions on various organs of the body such as analgesia, unconsciousness, depression of reflexes, muscular relaxation, etc., undesired, unanticipated, and unrecognized side effects may occur with resultant marked alteration in physiological functions and possibly great danger or serious effects for the patient.

The medically trained individual who uses anesthetic agents, constantly should be on the alert to counter all possible physiological changes they produce. Early warning signs such as diminished tidal exchange and minute volume should be met by assisted or augmented respiratory exchange; respiratory obstruction whether due to secretions, relaxed tongue, foreign body, or pathological tissue should be corrected immediately. Cardiac rate and rhythm should be observed continuously and any changes evaluated, as should elevations or depressions of blood pressure. Blood and fluid loss should be equated, with replacement as indicated. Abolition of protective reflexes should be recognized and respected.

The prompt and efficient recognition and treatment of factors of physiological alteration will:

1. Greatly enhance the safety of the patient.
2. Permit more rapid and better surgical interventions.
3. Probably contribute to a more rapid and pleasant convalescence.

Attention to seemingly minor factors early in their origin may prevent major physiological upsets in the course of anesthetic administrations!

3:00

### FINAL INTERMISSION TO VIEW EXHIBITS

## PROGRAM

### 3:30 "CROSS COUNTRY PANEL ON CARDIO-VASCULAR DISEASES"

**Moderator:** JOHN M. MURPHY, M.D., Detroit, Michigan

*Physician, Department of Cardiology, Harper Hospital; Senior Physician and Chief of Medical Department, St. John Hospital; Physician, Medical Department, Bon Secours Hospital; Fellow American College of Physicians; Fellow American College of Cardiology; Diplomate American Board of Internal Medicine.*

ARTHUR C. CORCORAN, M.D., Cleveland, Ohio  
*Vice Chairman, Research Division, Cleveland Clinic*

GEORGE R. MENEELY, M.D., Nashville, Tennessee

*Associate Professor of Medicine, Vanderbilt University School of Medicine and Associate Professor of Clinical Medicine and Cardiology, Meharry Medical College*

CHARLES A. POINDEXTER, M.D., New York, New York

*Professor of Medicine, New York University Postgraduate Medical School; Chief Division of Cardiology, N. Y. University-Bellevue Medical Center; Consultant in Cardiology, St. Francis Hospital, Port Jervis, N. Y.; Elizabeth A. Horton Hospital, Middletown, N. Y.; Tuxedo Memorial Hospital, Tuxedo Park, N. Y.; Phelps Memorial Hospital Association, N. Y., and Goshen Hospital, Goshen, N. Y.*

MYRON PRINZMETAL, M.D., Beverly Hills, California

*Associate Professor of Medicine, University of California School of Medicine at Los Angeles; Senior Attending Physician at Cedars of Lebanon Hospital; Chief of Cardiology, City of Hope Hospital, Duarte, California; Member of Heart Council, U.S.P.H.S., Bethesda, Maryland; Editorial Board, American Heart Journal, Heart Bulletin and Disease of the Month*

5:00 END OF SIXTH ASSEMBLY

## —Program of Sections—

### FRIDAY AFTERNOON

September 28, 1956

#### SECTION ON ANESTHESIOLOGY

Meeting—5:00 to 6:00 p.m.—Parlors G-H-I

**Chairman:** F. E. GREIFENSTEIN, M.D., Detroit

#### "SINGLE VERSUS MULTIPLE AGENTS FOR ANESTHETIZATION"

O. SIDNEY ORTH, M.D., Madison, Wisconsin

The popular present-day tendency in general anesthetic administrations is to use a multiplicity of agents whether they be a mixture of several gaseous agents, several volatile agents, several intravenous agents, or a combination of several of these groups of agents! From the widespread present-day usage of multiple anesthetic agents it is obvious that in many, many instances very satisfactory results can be obtained. The question is being raised with increasing frequency, however, as to whether such mixtures are the safest for the patient. When untoward effects occur can we assess quickly which agent is at fault and eliminate its actions? It is relatively certain that we cannot, or frequently that there is disguise of such effects, and serious to fatal consequences may arise. The supposition that "all the advantages and none of the disadvantages are obtained by multiple agents" might with equal logic be given the reverse twist of "all the disadvantages without the advantages"! Statistics so far available support this latter interpretation. A plea

is made for the use of individual agents where very specific need for several agents is not present. It is axiomatic that one or two drugs can be understood or respected better than a pot-like mixture. The general trend in medical therapy in the 20th century has been for the use of specific and minimal drugs rather than generalized mixtures. Is our specialty to be an exception?

#### SECTION ON DERMATOLOGY AND SYPHILOLOGY

Meeting—5:00 to 6:00 p.m.—Pan American Room

**Chairman:** OWEN S. HENDREN, M.D., Pontiac

**Secretary:** COLEMAN MOPPER, M.D., Detroit

#### "NEW, NEWER, AND NEWEST IN DERMATOLOGY"

HERBERT S. RATTNER, M.D., Chicago, Illinois

#### SECTION ON MEDICINE

Meeting—5:00 to 6:00 p.m.—Grand Ballroom

**Chairman:** R. A. GERISCH, M.D., Detroit

**Secretary:** BENJAMIN B. BLUM, M.D., Petoskey

#### "CURRENT STATUS OF THE PREGNANT CARDIAC"

JACK M. KAUFMAN, M.D., Detroit

*Assistant Professor, Physical Diagnosis and Internal Medicine, University of Detroit Dental School, Receiving Hospital, Wayne University College of Medicine*

The physiology of changing blood volume, cardiac output, and heart work is discussed in relation to pregnancy. Citing our own cases and from data accumulated from various workers in the field the following conclusions are arrived at: (1) Risk of pregnancy in most cardiacs is minimal when proper cardiac care is instituted. (2) Cyanotic and congenital heart disease is no longer contra-indication to pregnancy. (3) Therapeutic abortion for cardiac reasons is no longer tenable. (4) Patients who have had cardiac surgery including mitral commissurotomy, pulmonary valvulotomy and Blalock-Taussig operations are capable of having a low risk pregnancy.

In those cases where therapeutic abortion would formerly have been considered, mitral commissurotomy or other cardiac surgery can be safely performed during pregnancy. The risk to the fetus is practically nil and the risk to the mother is not much higher than therapeutic abortion.

#### SECTION ON PATHOLOGY

Meeting—3:00 p.m.-5:00 p.m.—English Room  
Cocktails—6:00 p.m.; Dinner—7:00 p.m.; Business Meeting—8:00 p.m.—English Room.

**Chairman:** C. ALLEN PAYNE, M.D., Grand Rapids

#### "A SLIDE SEMINAR ON DISEASES OF LOWER RESPIRATORY TRACT"

AVERILL A. LIEBOW, M.D., New Haven, Connecticut.

P.M.

6:00 END OF SCIENTIFIC ASSEMBLY AND OF THE 1956 ANNUAL SESSION.

# Annual Reports

## ANNUAL REPORT OF INDUSTRIAL HEALTH COMMITTEE—1955-1956

The committee continued the four objectives of activity adopted last year to improve the relationship of medicine to industry.

Members of the committee participated in the sessions of the AMA Congress on Industrial Health and the arrangements therefore held in Detroit in January 1956.

A well attended meeting of the Committee was held in Detroit on January 22, 1956. Several nationally prominent physicians in this field attended and contributed greatly to the deliberation.

At this meeting a subcommittee was appointed to draw up a Medical Plan for Small Plants utilizing physicians in private practice. After such a plan is formulated and approved it is to be used to stimulate improved industrial health programs throughout the state. This to be done by local medical societies.

The committee will undertake to stimulate interest in this field at the annual meeting of MSMS through the newly established Section on Occupational Health.

Respectfully submitted,

O. J. JOHNSON, M.D., *Chairman*  
O. J. PRESTON, M.D., *Vice Chairman*  
S. E. ANDREWS, M.D.  
J. D. BEALL, M.D.  
T. I. BOILEAU, M.D.  
H. S. BROWN, M.D.  
M. R. BURNELL, M.D.  
W. P. CHESTER, M.D.  
E. B. CUDNEY, M.D.  
E. A. IRVIN, M.D.  
M. W. JOCZ, M.D.  
D. F. KUDNER, M.D.  
V. S. LAURIN, M.D.  
E. F. LUTZ, M.D.  
C. P. MCCORD, M.D.  
G. P. MOORE, M.D.  
R. D. MUDD, M.D.  
P. J. OCHSNER, M.D.  
H. A. PINKERTON, M.D.  
D. M. RICHMOND, M.D.  
N. W. SCHOLLE, M.D.  
M. W. SHELLMAN, M.D.  
S. D. STEINER, M.D.  
A. J. SWINGLE, M.D.  
C. D. SELBY, M.D., *Advisor*

## ANNUAL REPORT OF THE TUBERCULOSIS CONTROL COMMITTEE—1955-1956

The Committee met on November 30, 1955. The principal items brought up for discussion before the Committee were as follows:

*Tuberculosis Circular for General Practitioners:* The Chairman and Committee members reaffirmed that much of the future effectiveness in tuberculosis case finding and treatment will depend upon the general practitioner in Michigan and other physicians in private practice. The pamphlet, "Drugs in the Treatment of Tuberculosis" prepared by the Joint State Committee on Tuberculosis, was approved for distribution.

Mr. Werle, Secretary of the Michigan Tuberculosis Association, reported that the Board of Directors of that association had agreed to underwrite the cost of printing and folding of these leaflets, providing the mailing services of the M.S.M.S. were available. The Committee expressed their thanks to the Michigan Tuberculosis Association for their offer to aid in the distribution of this pamphlet. Subsequent to the meeting of the

Committee, this pamphlet has been distributed to the physicians throughout the state.

*Proposed State Tuberculosis Control Budget:* Dr. Heustis, Commissioner of Health, presented the 1956-57 budget requests for the tuberculosis control program of the Michigan Department of Health. The proposed 1956-57 budget totaled \$8,305,061 including \$140,223 for case finding and case holding activities, \$2,298,338 for subsidy of state-at-large tuberculosis patients and \$5,866,500 for state subsidies to local health departments and sanatoriums, administered by the Michigan Department of Health.

The Committee discussed the budget at length, emphasizing the principles involved more than the actual amounts of money requested. It was agreed that the budget request was too detailed and far-reaching for proper appraisal within the time limits of this Committee meeting. It was agreed that Dr. Heustis should submit summary copies of the budget proposal to Committee members for their study and comment.

*Tuberculosis Sanatorium Bed Study:* Dr. Hofstra and Dr. Heustis distributed preliminary reports on the utilization of tuberculosis hospital beds in Michigan. Dr. Hofstra explained that the pattern of hospitalization was governed by: (a) the proximity of available facilities, (b) the patient's choice, (c) the necessity of hospitalizing patients outside the area of residence due to lack of available beds, and (d) the willingness of the patient to accept hospitalization at any facility. He also emphasized that utilization of available beds was dependent upon (1) case finding and (2) the ability to motivate persons with active tuberculosis to accept hospitalization.

It was pointed out by Dr. Heustis that the tuberculosis case load in southeastern Michigan does not appear to be dropping, although the load is gradually declining in other areas of the state. A preliminary draft of this survey report ended with the following recommendations: (1) That excess beds be used for treatment and care of diseases which will permit flexibility of the utilization and of the beds to meet varying and largely unpredictable demands of tuberculosis, (2) That all areas of Michigan be provided with at least minimum facilities to maintain adequate tuberculosis control, including outpatient and diagnostic services, (3) That southeastern Michigan be encouraged to continue to use beds available in other areas until such time as the need for such beds no longer exists in southeastern Michigan.

*Tuberculosis Education for General Practitioners:* The Committee recognized the increasing dependency upon general practitioners for tuberculosis case finding. Ways and means to stimulate the interest of the general practitioner in the differential diagnosis of diseases in the chest were discussed.

It was agreed that a handbook of chest diseases containing x-ray illustrations would be highly valuable and the Committee recommends that the MSMS sponsor the production and distribution in serial form of a chest disease atlas for use by general practitioners and other doctors of medicine as an aid in the differential diagnosis of diseases of the chest, with an understanding that \$10,000 for such a project is available from the Michigan Tuberculosis Association. It is further recommended that the M.S.M.S. undertake the responsibility for the preparation of such an atlas and its mailing to members of the M.S.M.S. It is planned to have the initial distribution consist of a loose-leaf binder with probably 40 or 50 various chest disorders with accompanying descriptive material. Subsequent serial addi-

## ANNUAL REPORTS

tions would in time make this a valuable x-ray atlas on diseases of the chest.

**New Tuberculin:** The State Health Commissioner distributed samples of the new strength tuberculin, namely, 1-3300, and briefly explained the new improved product. It was agreed that the Committee recommend that an article be prepared for an early issue of THE JOURNAL of the MSMS by the Michigan Department of Health concerning the new tuberculin available from the State Health Department and its use in the private office of the doctor of medicine in Michigan.

**X-Ray Survey Project in Southeastern Michigan:** Plans for a mass x-ray survey to be conducted in southeastern Michigan, in June, 1956, were discussed. It was agreed by the Committee that recognizing that the 70 mm x-ray is a screening device for detecting tuberculosis, and recognizing that the effectiveness of a mass survey is better served by making a 14 x 17 film where there is a suspicion of chest disease so that such suspected disease may be better identified in the screening process.

Mr. Werle, Secretary of the Michigan Tuberculosis Association, reported that there had been a greater response by county medical societies to the offer of the Michigan Tuberculosis Association to supply tuberculosis speakers to county society meetings at no cost to the county society.

Among the guests present at the Committee meeting were: State Senator Creighton Coleman; Mr. Theodore J. Werle, Executive Directive of the Michigan Tuberculosis Association; Mr. Tilden B. Mason, Senior Research Associate of the Citizens Research Council of Michigan, and Mr. Aaron Englisher, of Public Administration Service, Chicago, Director of a current survey on tuberculosis and mental health being made for the Michigan Legislature at the direction of the Senate Finance Committee.

The hospital problem relative to the mental patients in Michigan was discussed freely by the Committee members and guests. Various viewpoints on the use of current tuberculosis facilities for housing the mentally retarded were expressed, but no definite action was taken by the Committee; still it was generally agreed that out of the free discussion came a better understanding of the problem by all persons concerned.

J. W. TOWEY, M.D., *Chairman*  
W. B. HOWES, M.D., *Vice Chairman*  
P. T. CHAPMAN, M.D.  
W. N. DAVEY, M.D.  
J. L. EGLE, M.D.  
L. R. NELSON, M.D.  
R. L. RAPPORT, M.D.  
W. F. STEPHENSON, M.D.  
A. F. STILLER, M.D.  
C. J. STRINGER, M.D.  
KIYO TASHIRO, M.D.  
S. A. YANNITELLI, M.D.  
G. T. MCKEAN, M.D., *Advisor*

### ANNUAL REPORT OF IODIZED SALT COMMITTEE—1955-1956

Our educational program has been continued and enlarged in scope. Dr. Richard Waggoner of St. Louis, Michigan, has developed a motion picture depicting the importance of iodized salt in the prevention of goiter. The movie includes scenes of the Michigan Salt Company of St. Louis and the school children being examined for goiter. Dr. Robert Moehlig is working with Dr. Waggoner on the completion of this movie and it will then be available for use throughout the state.

Dr. Waggoner attended the meeting of the American Salt Producers Association in an attempt to impress upon them the great opportunity they have to benefit the health of this nation by putting a small amount of iodine in all food salt.

Dr. Moehlig reported on the increased incidence of multiple sclerosis in endemic goiter areas, also the incidence of cretinism and other mental deficiencies.

The expanding educational program is being carried out to keep the importance of purchasing iodized salt before the homemaker and grocery buyer.

A communication was received from The Child Welfare Committee urging that all food salt in Michigan be iodized. This was discussed by the Committee and it was moved that our Committee endorse this motion and the similar proposal of the American Public Health Association Committee for Endemic Goiter that all food salt in the United States be iodized.

Word was received that the Executive Committee of our State Society adopted a motion "that the Michigan State Medical Society favor any method, short of compulsory legislation, to promote greater use and manufacture of iodized salt."

Our educational program is bearing excellent results in our state and we are striving to keep it at its present high level of effectiveness.

A meeting was held February 28, 1956.

Respectfully submitted,

B. E. BRUSH, M.D., *Chairman*  
H. A. TOWSLEY, M.D., *Vice Chairman*  
L. A. BERG, M.D.  
J. B. BLODGETT, M.D.  
J. R. CARNEY, M.D.  
R. C. MOEHLIG, M.D.  
R. L. RAPPORT, M.D.  
J. M. SCHROEDER, M.D.  
R. L. WAGGONER, M.D.

### ANNUAL REPORT OF THE MEDIATION COMMITTEE—1955-1956

During this time there have been no complaints submitted to the Committee and there have been no meetings held.

Respectfully submitted,

RALPH WADLEY, M.D., *Chairman*  
L. R. LEADER, M.D., *Vice Chairman*  
D. R. BOYD, M.D.  
A. E. GAMON, M.D.  
W. Z. RUNDLES, M.D.  
R. W. TEED, M.D.  
CHARLES TEN HOUTEN, M.D.

### ANNUAL REPORT OF CHILD WELFARE COMMITTEE—1955-1956

The Child Welfare Committee of the Michigan State Medical Society and its subcommittees present herewith a brief summary of its activities for the past year:

The General Committee considered and recommended to the Michigan State Medical Society subjects relative to the general medical welfare of the children in the State of Michigan: school health problems, oxygen in the care of prematures, poliomyelitis vaccine, the handicapped child, and means of extending the activities of the Committee to the County Medical Society level.

To facilitate functioning of the general Committee, it was also recommended that this Committee consist of the Chairman, a representative of the State Health Department and the Michigan Crippled Children Commission, and the chairman of several subcommittees. The possibility of expanding its activities through more subcommittees was explored.

The Subcommittee of Ophthalmologists reviewed problem of prophylaxis for eyes of newborn and recommended that the present Michigan law not be changed. The Subcommittee also made suggestions concerning visual requirements for pre-school and school

(Continued on Page 886)

## John A. MacCartney

### President, American Pharmaceutical Association

When John A. MacCartney took over the job as President of the American Pharmaceutical Association at its 103rd Annual Convention in Detroit last April, his friends confidently predicted that Mr. MacCartney would be the most active president in the history of the A.Ph.A. . . . and he is off to a flying start.

In his inaugural address, he emphasized the part that pharmacy has played in the progress of medical care, and stressed the need for harmony and co-operation with "other members of the health team." He outlined the need for a hard hitting public relations program and urged American pharmacists to co-ordinate their efforts "toward the ultimate goal that the public will accept and approve the retail drug stores of this country as the logical outlet for the products of the drug industry," not by "blind dependence on legal restrictions" but by conducting the profession in such a manner that the public "approves and prefers us because they want to, not because they have to." He immediately set about to put his ideas into action.

Mr. MacCartney, Professional Relations Manager for Detroit's Parke-Davis & Company since 1946, and associated with that pharmaceutical firm for twenty-seven years, already is well-known to many members of MSMS.

Born fifty years ago in Claysville, Pennsylvania, "Mac" MacCartney has literally been associated with the pharmaceutical business all his life. He "learned the hard way," starting in his earliest years by mopping the floors and washing the bottles in the drugstore operated by his father in Claysville for fifty years.

Following his graduation from the University of Pittsburgh College of Pharmacy in 1928, he joined the sales force of Parke-Davis, soon becoming a medical service representative with headquarters at Erie, Pennsylvania. From 1935 to 1942, his headquarters were at Rochester, New York, before he received a call to active duty with the Army. His war record included two years in the Pacific area, much of it with the 77th Infantry Division in the Philippine and Okinawa campaigns. Later he served as Chief of Medical Supply for the U. S. Military Government in Korea. He holds the rank of lieutenant colonel.

Mr. MacCartney already is widely known for his work in the field of public relations and trade relations in pharmacy and medicine. As a traveling ambassador

for Parke-Davis, he has spoken before hundreds of meetings of pharmaceutical and medical groups. His duties also include supervision of the Parke-Davis professional visitor program in which the company plays host to 10,000 physicians, dentists, hospital personnel and related groups each year on a ten-mile tour of the Parke-Davis laboratories in Detroit. He is also in charge of the Company's exhibits at such meetings as the MSMS annual session, the Michigan Clinical Institute, and other professional conventions and meetings throughout the nation.

Mr. MacCartney's leadership should further strengthen the bond between the 30,000 members of A.Ph.A. and the members of medical organizations in this nation, a goal which MSMS has been encouraging on a statewide level with great success during the past few years.



A RESEARCH MILESTONE

# Nilevar\*

(BRAND OF NORETHANDROLONE)

## Searle's New and Practical Steroid Specifically for Protein Anabolism—

It has long been recognized that a substance which would promote protein anabolism would be of inestimable value in therapy. The androgens have this property, but unfortunately they also exert actions on secondary sex characteristics. These effects are commonly undesirable in therapeutic programs.

**THE FIRST STEROID WITH ANABOLIC SPECIFICITY—** Nilevar, the newest Searle Research development, therefore, meets a long desired clinical need because Nilevar presents the first steroid primarily anabolic for protein synthesis. Moreover, Nilevar is without prominent androgenic effects (only about one-sixteenth of that exerted by the androgens).

**OBJECTIVE AND SUBJECTIVE RESPONSE —** Orally effective, Nilevar therapy is characterized by retention of nitrogen, potassium, phosphorus and other electrolytes in ratios indicative of protein anabolism. Moreover, subjectively the patient observes an increase in appetite and sense of well-being.

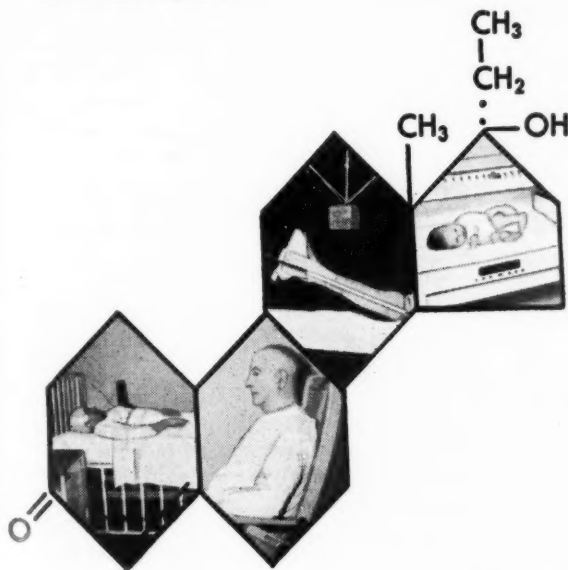
**WELL TOLERATED —** Nilevar has an extremely low toxicity. Laboratory animals fail to show toxic effects after six months of continuous administration of high dosages. Nilevar should not be administered to patients with prostatic carcinoma. Nausea or edema may be encountered infrequently. Slight androgenicity may be evidenced on high dosage or in particularly responsive individuals.

**MAJOR INDICATIONS—**Preparation for and recovery from surgery; supportive treatment of serious illnesses (pneumonia, poliomyelitis, carcinomatosis, tuberculosis); recovery from severe trauma and burns; decubitus ulcers; care of premature infants.

**DOSAGE—**The daily *adult* dose is three to five Nilevar tablets (30 to 50 mg.) but up to 100 mg. may be administered. For *children* the average daily dose is 1 to 1.5 mg. per kilogram of body weight; individual dosages depend on need and response to therapy.

**SUPPLY—**Nilevar is available in uncoated, unscored tablets of 10 mg. G. D. Searle & Co., Research in the Service of Medicine.

\*Trademark of G. D. Searle & Co.



SEARLE

# Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

## LEGISLATION OF PUBLIC HEALTH SIGNIFICANCE

A number of measures enacted by the 1956 Legislature are of concern to public health.

*Appropriations; Public Health.*—Grants to counties were increased from \$325,000 to \$400,000. Appropriations for tuberculosis case finding were increased from \$175,000 to \$250,000. A sum of \$14,119 was appropriated to execute the newly assigned responsibility for Act 139, namely, the special program of licensing of nursing homes and homes for the aged (P.A. 219).

*Poliomyelitis Vaccine.*—The 1955 appropriation of \$2,000,000 for the purchase of poliomyelitis vaccine was extended for use throughout the fiscal year 1956-57. This appropriation is to be reduced by the amount of any federal money received by the State of Michigan for the purchase of poliomyelitis vaccine (P.A. 13).

*Dry Cleaning Law.*—Was amended to more definitely recognize the health implications of dry cleaning with certain solvents. The law as amended also allows discretion in the establishment of dry cleaning plants in buildings containing places of public assembly and provides for approval of construction items in certain types of dry cleaning establishments (P.A. 167).

*Nursing Homes.*—The licensing of nursing homes and home for the aged was transferred from the Department of Social Welfare to the Health Department, effective January 1, 1957. A small amount of money has been provided for this activity. The legislation makes meager reference to full time local health departments in its context (P.A. 139).

*County Drain Law.*—This is a codification of the county drain law. A few minor amendments were also made, one extending the life of drain bonds, one permitting the transfer of jurisdiction over a drain which lies wholly within one city or village, and one having to do with procedures where a portion of the district is in the process of incorporating as a city (P.A. 40).

*Water and Sewer Law.*—Amends the county water and sewer law (Act 342, P.A. 1939) to authorize two counties to join in establishing water, sewerage and garbage disposal facilities; also governs procedure where township is in process of incorporating as a city (P.A. 49).

*Trailer Coach Parks.*—Amends trailer coach park act with respect to collection and distribution of fees (P.A. 129).

*State Milk Law.*—Amends Act 169, P.A. 1929 (State Milk Law) providing for sale of milk from dairy-sealed containers, served from refrigerated bulk milk dispensers. Provides for report of location of such dispensers to Department of Agriculture, equipment to be in sanitary surroundings, served in quantities of not less than 8 ounces; each can to carry date of pasteurization (P.A. 200).

*Milk.*—A new act applying to production, handling and sale of Grade A milk and milk products; defines Grade A milk and establishes standards; provides for producer permits; includes powers to political subdivisions contained in Sec. 14, Act 169, P.A. 1929 (P.A. 216).

*Water.*—Provides authority to Water Resources Commission to foster and encourage formation of water supply and sewage disposal districts; to act as administrative agency in formation of districts, and lend assistance to directors of districts as may be appropriate; to negotiate contracts in such matters; to take advantage of any Federal legislation; to disburse moneys; to act as fiscal agent for State for making funds available to districts that may be appropriated by Legislature; to co-ordinate its duties and functions with similar duties performed by other state agencies. Provides procedures for forming such districts by two or more units of government (P.A. 211).

## TRAINING COURSES FOR VISION AND HEARING TECHNICIANS

Three training courses for vision-screening technicians are scheduled for this summer. One will be held at Michigan State Normal College, Ypsilanti, from June 25 to 29. The second will be at Central Michigan College, Mt. Pleasant, July 9 to 13. The third will take place at Northern Michigan College, Marquette, July 16 to 20.

A training course for hearing-screening technicians was held at Michigan State Normal College, from June 17 to 22.

The technicians satisfactorily completing the courses will be employed locally in vision and hearing programs.

One half of all patients with ovarian cancer are hopelessly incurable when first diagnosed.

\* \* \*

Ovarian cancer comprises 4 per cent of all cancers in women over forty.

\* \* \*

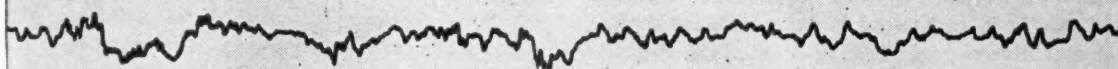
Ovarian tumors may remain entirely asymptomatic for long periods.

\* \* \*

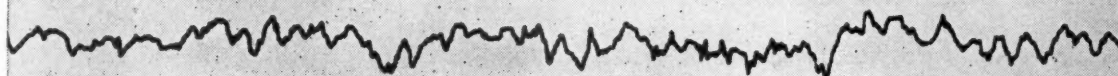
Eighty per cent of Krukenberg tumors are bilateral.

## WHAT IS THE DIFFERENCE BETWEEN A TRANQUILIZER AND A SEDATIVE?

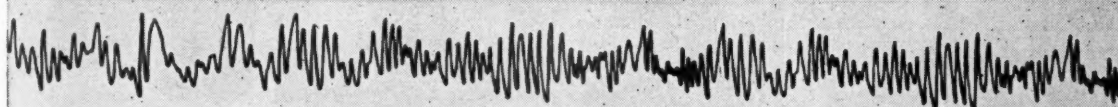
*Comparison of the effect of Raudixin (tranquilizer) and a  
barbiturate (sedative) on the cortical electroencephalogram*



No drug.



After Raudixin. E. E. G. not altered.



After barbiturate. Typical "spindling" effect.

Because barbiturates and other sedatives depress the cerebral cortex, the sedation achieved is accompanied by a reduction in mental alertness.

Raudixin acts in the area of the midbrain and diencephalon, and does not depress the cerebral cortex. Consequently, the tranquilizing (ataractic) effect achieved is generally free of loss of alertness.

## RAUDIXIN

Squibb Whole Root Rauwolfia Serpentina

**DOSAGE:** 100 mg. b.i.d. initially; may be adjusted within a range of 50 mg. to 500 mg. daily. Most patients can be adequately maintained on 100 mg. to 200 mg. per day.

**SUPPLY:** 50 mg. and 100 mg. tablets; bottles of 100, 1000 and 5000.

**SQUIBB**



*Squibb Quality—the Priceless Ingredient*

\*RAUDIXIN® IS A SQUIBB TRADEMARK

JULY, 1956

*Say you saw it in the Journal of the Michigan State Medical Society*

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## In Memoriam

**R. Philip Sheets, M.D.**, Superintendent of Traverse City State Hospital since 1931, died March 8, 1956, at the age of sixty-three. He was born in Little Rock County, Ark.; received his M.D. degree from the University of Arkansas. He had served on the staff of Traverse City State Hospital since 1923.

**Charles J. Bloom, M.D.**, who had practiced in Muskegon for forty-two years, died February 19, 1956, at the age of seventy-three. He was born in Sweden; received his M.D. degree at the University of Minnesota.

**Donald A. Cowan, M.D.**, of Sault Ste. Marie, Director of the Chippewa-Luce-Mackinac Health Unit since 1948, died March 12, 1956, at the age of forty-eight. He was born in Oxford; received his M.D. degree at the University of Michigan Medical School; was intern and assistant resident in pediatrics at the University Hospital, and resident at Northern Michigan Children's Hospital, Marquette.

**Sylvester Ford, M.D.**, Detroit radiologist, died March 11, 1956, at the age of forty-nine. He was born in Ann Arbor; graduated from the University of Michigan Medical School; served his internship at Blodgett Memorial Hospital, Grand Rapids, and Grace Hospital, Detroit. He established practice in 1931.

**John E. Gleason, M.D.**, who practiced in Detroit for fifty-three years, died March 19, 1956, at the age of seventy-seven. He was born in Oxford, N. Y.; graduated from the University of Michigan Medical School. His specialty was eye, ear, nose, and throat.

**Thomas E. Hackett, M.D.**, who had practiced in Jackson since 1912, died April 11, 1956, at the age of sixty-eight. He was born in Dowagiac; graduated from the University of Michigan Medical School. He was the father of Thomas L. Hackett, M.D., Jackson, and Daniel J. Hackett, M.D., Pontiac.

**William L. Helkie, M.D.**, retired Three Oaks physician, died March 5, 1956, at the age of eighty-five. He was born in Essex County, Ontario; received his M.D. degree from Detroit Medical College; served his internship at St. Mary's Hospital, Detroit. He practiced in Three Oaks for fifty-five years until 1951. He was an Emeritus Member of MSMS.

**Howard C. Jackson, M.D.**, of Kalamazoo, son of John B. Jackson, M.D., died March 21, 1956, at the age of forty-eight. A graduate of Harvard University Medical School, he interned at Peter Bent Brigham Hospital, Boston; held residencies in pathology and surgery at Lakeside Hospital, Cleveland, and University Hospital, Ann Arbor. He was president-elect of the Kalamazoo Academy of Medicine, and president of MSMS in 1926.

**Arthur W. McGarvah, M.D.**, who had practiced twenty-four years in Detroit, died February 17, 1956. He was born in Windsor, Ontario; received his M.D. degree from University of Toronto; served internship at Harper Hospital and residency at Woman's Hospital, Detroit.

**George F. Muehlig, M.D.**, lifelong resident of Ann Arbor, died March 31, 1956, at the age of sixty-seven. He graduated from the University of Michigan Medical School; had been a member of St. Joseph's Mercy Hospital staff for the past forty-four years.

**Wells C. Reid, M.D.**, Superintendent of Goodrich General Hospital since 1919, died February 26, 1956, at the age of sixty-nine. He was born in Genesee County; received his M.D. degree at Washington University Medical School, St. Louis, Mo.

**Arthur J. Reynolds, M.D.**, Flint physician for more than fifty years, died February 26, 1956, at the age of seventy-five. A graduate of the University of Michigan, he interned at University Hospital. He was a Life Member of MSMS.

**William A. Spitzley, M.D.**, Detroit surgeon since 1902, died March 17, 1956, at the age of eighty-three. He was born in Detroit; received his M.D. degree at the University of Michigan. He was an author and teacher in surgery.

**Karl L. Swift, M.D.**, of Detroit, died March 24, 1956, at the age of fifty-eight. He was born in Edmore; received his M.D. degree at Wayne University College of Medicine; was senior attending physician in general practice at Woman's Hospital.

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The banking institution that makes unsecured loans to all applicants soon finds its resources exhausted and goes into bankruptcy. The private health organization that offers to meet the needs of all patients in its special category soon bankrupts its own resources and disrupts the facilities of all official welfare agencies in its field.

\* \* \*

The provision of service to all comes in time "snowballs" to the point where it becomes impossible to satisfy all demands and results in an appeal to government agencies to take over the problem. In this way, socialism gains control.

# WHY SENSITIZE

*in topical and ophthalmic infections*

# USE 'POLYSPORIN'<sup>®</sup>

POLYMYXIN B-BACITRACIN OINTMENT brand

*to insure broad-spectrum therapy  
with minimum allergenicity*

For topical use: in ½ oz. and 1 oz. tubes.

For ophthalmic use: in ¼ oz. tubes.



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JULY, 1956

Say you saw it in the Journal of the Michigan State Medical Society

857



## NEWS MEDICAL

### MICHIGAN AUTHORS

Jay P. Sanford, First Lieutenant, MC, USAR, Philip A. Riley, Jr., Captain, MC, USAR and Lester R. Sauvage, Captain, MC, USAR, Washington, D. C., are the authors of an article entitled "Evaluation of Orlon Fabric in the Repair of Defects in the Abdominal Wall," published in *Surgery*, February, 1956. Dr. Riley will soon be associated with his father in Jackson.

Martin J. Urist, M.D., South Haven, is the author of an article entitled "The Surgical Treatment of Esotropia with Bilateral Depression in Adduction," published in *AMA Archives of Ophthalmology*, May, 1956.

J. S. DeTar, M.D., Milan, is the author of an article entitled "Modern Medical Care," published in *GP*, May, 1956.

Harry M. Nelson, M.D., Detroit, and Peggy Jean Howard, M.D., Louisville, Kentucky, are the authors of an article entitled "Breast Cancer during Pregnancy and Lactation," published in *Clinical Medicine*, April, 1956.

W. M. Mikkelsen, M.D., H. A. Zevely, M.D., N. H. Chatelin, M.D., I. F. Duff, M.D., and A. J. French, M.D., Ann Arbor, are the authors of an article entitled "A Clinicopathologic Study of Fifty Cases of "Connective Tissue Disease," published in the *University of Michigan Medical Bulletin*, April, 1956.

Christopher Deen, M.D., M.S., Detroit, is the author of an article entitled "Pathological Survey of Malignant Melanomas of the Uveal Tract Received at the Kresge Eye Institute," published in the *Kresge Eye Institute Bulletin*, Vol. VII, Number 1.

J. Chandler Smith, M.D., Saginaw, is the author of an article entitled "Superiority of Surgical Treatment of Endometrial Carcinoma," published in *The Journal of the American Medical Association*, April 28, 1956.

Leo J. Kenney, M.D., and William R. Eyler, M.D., Detroit, are the authors of an article entitled "Preoperative Diagnosis of Sequestration of the Lung by Aortography," published in *The Journal of the American Medical Association*, April 28, 1956.

T. Francis Jr., M.D., R. F. Korn, R. B. Voight, M. Boisen, F. M. Hemphill, J. A. Napier and E. Tolchinsky, from the Poliomyelitis Vaccine Evaluation Centre, University of Michigan, Ann Arbor, are the authors of an article entitled "Evaluation of 1954 Field Trial of Poliomyelitis Vaccine: Summary Report," *Medical Proceedings*, 1:141-145, 1955.

J. C. Smith, M.D., Saginaw, is the author of an original article, "Superiority of Surgical Treatment of Endometrial Carcinoma," which appeared in *JAMA*, April 22, page 1460.

L. J. Kenney, M.D., and W. R. Eyler, M.D., Detroit, are authors of an article which appeared in "Clinical Notes" of *JAMA*, April 28, page 1464, entitled "Preoperative Diagnosis of Sequestration of the Lung by Aortography."

D. C. Smith, M.D., and G. C. Brown, Sc.D., Ann Arbor, are co-authors of an original article entitled "Serologic Response of Infants and Preschool Children to Poliomyelitis Vaccine" which appeared in *JAMA*, June 2, 1956.

James Barron, M.D., J. J. Prendergast, M.D., and M. W. Jocz, M.D., all of Detroit, are authors of an article entitled "Food Pump," published in *JAMA* of June 16 under "Clinical Notes," page 621.

\* \* \*

C. Robert Dean, M.D., Director of the Rehabilitation Institute of Metropolitan Detroit, addressed the Canadian Tuberculosis Association at its annual meeting held in Niagara Falls, Ontario, on May 18, 1956. His address concerned the integration of services within a medical rehabilitation facility to provide good patient care.

\* \* \*

Russell S. Blanchard, M.D., physiatrist, has joined the staff of the Rehabilitation Institute as Clinical Director. Doctor Blanchard was formerly with the Department of Physical Medicine and Rehabilitation at the University of Minnesota.

\* \* \*

The Board of the American Legion Hospital, Battle Creek, Michigan, has announced the appointment of George S. Allen, M.D., as Medical Director. Dr. Allen comes to the American Legion Hospital from Mineral Springs Sanatorium, Cannon Falls, Minnesota. He graduated from the University of Rochester School of Medicine and for several years has been associated with Dr. Ezra Bridge, specializing in tuberculosis. Dr. Allen assumed his duties on June 1, 1956.

\* \* \*

Examinations for qualified fellows of the International College of Surgeons will be held in Chicago, July 23-24 and October 29-30, 1956.

Oral conferences will be held on August 6 and October 22.

For details, write to the Secretary of the Qualifications Council, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Illinois.

\* \* \*

The American College of Gastroenterology announces that its annual course in Postgraduate Gastroenterology

(Continued on Page 860)

# Only Meat ... is Meat

Suppose we suddenly found ourselves in a "Brave New World," in which all the rich protein, the B vitamins (including the important B<sub>12</sub>), the minerals, and all the other nutrients of a juicy steak or a succulent pork chop could be compressed into a capsule. Suppose we were to take one or two such capsules each day. What would happen?

Would we be just as healthy? Would we be as happy?

There is something about man's wish for meat that cannot be satisfied by chemical or mathematical analyses. The feeling of satisfaction, the downright enjoyment of biting into and chewing, the pleasurable effect of having eaten well . . . all these make meat more than just an impressive list of essential nutrients. Long before man knew anything about the science of nutrition he knew meat was part and parcel of his health and his joy of eating and of living.

Other foods may be fortified and enriched,  
*but none can ever take the place of meat.*

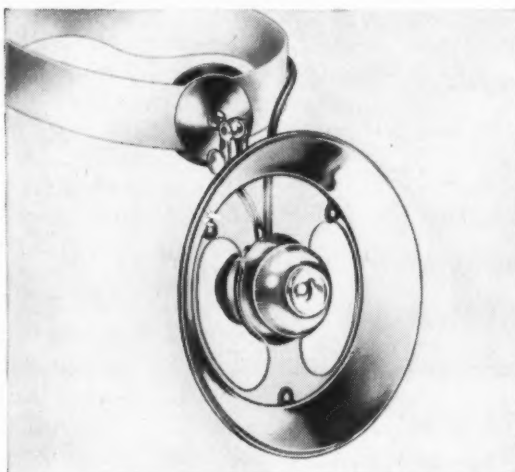
Only meat is meat.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

**American Meat Institute**  
Main Office, Chicago . . . Members Throughout the United States

No.  
460

## WELCH ALLYN HEADLIGHTS

No.  
450

May we suggest that you check *both* Welch Allyn types before you purchase your next headlight?

No. 460 is a superior, direct, focusing light, favored for its combination of great intensity with freedom from filament shadows and other imperfections in the light beam. Focuses down to a  $\frac{1}{2}$ " spot at 8" focal length or up to  $6\frac{1}{2}$ " at 13" focal length. Complete with transformer, \$28.00.

No. 450 is the unique Full Beam headlight, which provides an intense light covering a large area evenly without glare or specular reflection. Binocular vision through the beam preserves normal depth perception and eliminated visible shadows. Complete with transformer, \$36.00.

### NOBLE-BLACKMER, INC.

267 W. Michigan

28148

Jackson, Michigan

(Continued from Page 858)

will be given at The Roosevelt in New York City, October 18, 19, 20, 1956.

The course again will be under the direction and co-chairmanship of Dr. Owen H. Wangensteen, Professor of Surgery of the University of Minnesota Medical School, who will serve as surgical co-ordinator, and Dr. I. Snapper, Director of Medical Education, Beth-El Hospital, Brooklyn, N. Y., who will serve as medical co-ordinator. Drs. Wangensteen and Snapper will be assisted by a distinguished faculty selected from the medical schools.

The subject matter to be covered in the Course, from a medical as well as surgical viewpoint, will cover, essentially, the advances in diagnosis and treatment of gastrointestinal diseases and a comprehensive discussion of diseases of the mouth, esophagus, stomach, pancreas, spleen, liver and gallbladder, colon and rectum, with special studies of radiology and gastroscopy.

For further information and enrollment, write to the American College of Gastroenterology, Department P.G., 33 West 60th Street, New York 23, N. Y.

\* \* \*

**Colored Television.**—The Regents of the University of Michigan have accepted a gift to set up color television for use in surgical and clinical work at the University hospitals. The Herbert H. and Grace A. Dow Foundation of Midland made a grant of \$178,750 to be used for color television equipment—a regular portable television camera, a film television camera, control equipment, and a special television camera which will be mounted over the operating table.

The new equipment will be used specifically for teaching and will be available to telecast, nationwide if necessary, through local commercial stations in either color or black and white.

Besides teaching medical school students, Regent Charles Kennedy, Detroit surgeon, said the university also hoped to pass on to the hospitals and doctors of Michigan films and television versions of operations and clinics within the hospital.

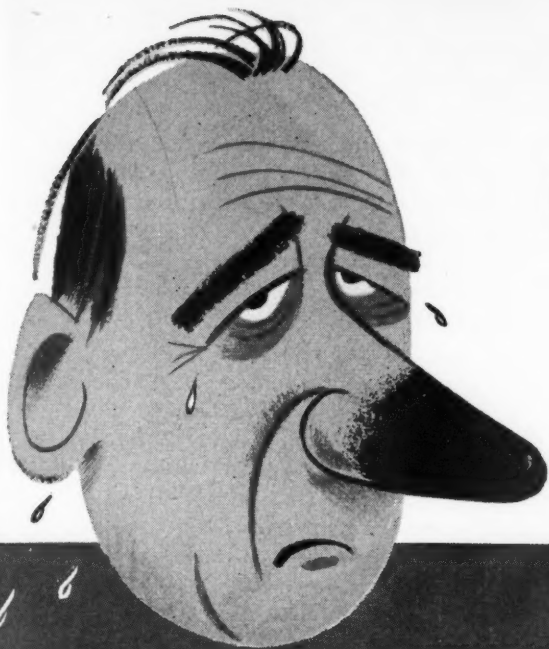
Earlier, the regents approved a plan for a medical center in connection with the hospital with facilities for closed circuit television to replace the older amphitheater methods of surgical observation and teaching.

Doctors, it was explained, feel that more students and doctors can experience better training through television than through old methods of direct observation.

\* \* \*

Selective Service headquarters has received a Defense Department requisition to draft 380 physicians for Navy duty. July will be the induction month and October-December the military activation period. SS data gathered from state directors indicate that the order can be filled without tapping any doctors in Priority III past age thirty. Of course, such registrants as may be available for military duty from Priorities I and II ranks are vulnerable for induction up to statutory age ceiling of forty-five.

(Continued on Page 862)



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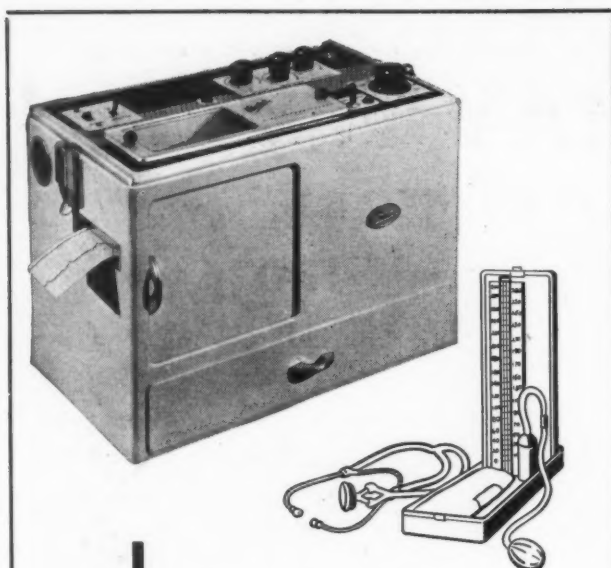


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(Continued from Page 860)

Neither Army nor Air Force is expected to call on SS for physicians, at least not before last quarter of 1956. Commissioning of a large crop of interns in July will help meet replacement requirements. Armed forces are hopeful that new career incentive law will reduce discharge rate and encourage voluntary procurement.—W.R.M.S., May 21, 1956.

\* \* \*

The Association of American Physicians and Surgeons has announced the 1957 Eleventh Annual Essay contest for high school students. This year there will be a choice of topics: "The Advantages of Private Medical Care" or "The Advantages of the American Free Enterprise System." There will be six national prizes of \$1,000; \$500; \$250; and three of \$25 each. County and state medical societies and auxiliaries are invited to sponsor like contests on a local level.

\* \* \*

The American Nurses Association, at the annual meeting in Chicago, May 14-18, 1956, through its House of Delegates, ratified opposition to commission survey scheme espoused by Rep. Frances Bolton (R., Ohio). ANA's position is that the profession can do better with more training subsidies and less investigating on part of government. The ANA also voted for amendment of the Taft-Hartley Act so as to enable nurses to engage in collective bargaining with hospitals on working conditions and salaries.

\* \* \*

Civilian Medical Care for Army Personnel.—Where regularly established medical care is not available, the services of civilian physicians and hospitals is necessary. First aid or emergency care is authorized at any time. Emergency medical care is that which is necessary to save life or limb, or to prevent great suffering. Surgical operations should not be performed without prior authorization of the surgeon of the nearest military installation unless indicated as an emergency procedure. Elective medical treatment by civilian doctors will not be authorized. Obligations resulting from attention to dependents of military personnel are the responsibilities of the dependents or their sponsors. There must be prior authorization before civilian medical care is given. Contact the nearest military authority. The process is complicated. New regulations have been issued by the Office of the Surgeon General.

\* \* \*

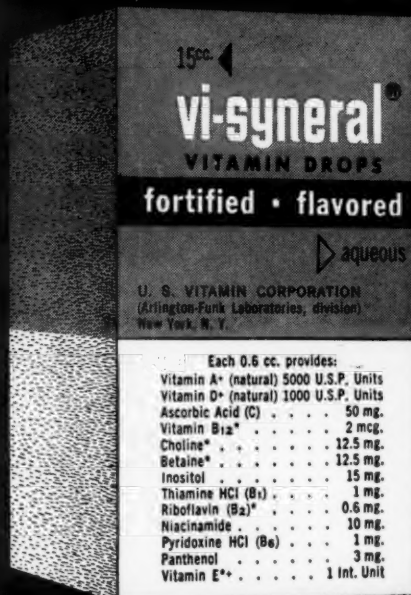
The National Tuberculosis Association, The American Trudeau Society, and the National Conference of Tuberculosis Workers held their annual meeting in New York City, May 20-25, 1956. The combined programs made a five-by-eight inch folder of 108 pages and cover. Michigan was well represented: H. M. Randall, Ph.D. of Ann Arbor, was part author of "Comparison of the Native Lipoids of Atypical Acid-fast Bacilli with the Lipoids of Known Mycobacterial Types." J. Richard Johnson, M.D., Nancy E. Furstenberg, M.D., Roy Patterson, M.D., Henry K. Schock, M.D., and Winthrop N. Davey, M.D., all of Ann Arbor, read a paper,

(Continued on Page 864)

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(Continued from Page 862)

"Corticotropin and Adrenal Steroids as Adjuncts to the Treatment of Tuberculous Meningitis." Wilbur J. Steininger, M.D., of Northville, gave a paper on "Characteristics of Patients in Tuberculosis Hospitals—A U. S. Public Health Service Co-operative Investigation." He also presented an exhibit. Paul T. Chapman, M.D., Ruth S. Tibbits, M.D., Carl C. Birkelo, M.D., and George J. Baer, M.D., Herman Kiefer Hospital, Detroit, had an exhibit on "Bone and Joint Tuberculosis." E. Osborne Coates, M.D., and Geoffrey L. Brinkman, M.D., of Henry Ford Hospital, Detroit, had a booth demonstrating "Aids in the Clinical Evaluation of Pulmonary Function."

\* \* \*

**New Vaccine.**—The Army Medical Department has announced the successful trial of a new respiratory disease vaccine which has reduced the incidence of hospitalized cases of respiratory disease by more than eighty per cent. The new vaccine reaches its maximum effectiveness within a week after administration. It was developed in the Walter Reed Army Institute of Research in Washington, D. C.

\* \* \*

**Citation.**—President Eisenhower has presented a citation for meritorious service to Admiral Ross T. McIntire, formerly Surgeon General for the Navy for work as chairman of the President's Committee on Employment of the Physically Handicapped, 1947 to 1954.

\* \* \*

The third National Cancer Congress sponsored by the American Cancer Society, Inc., the National Cancer Institute, and the U. S. Public Health Service, has just been held at the Sheraton-Cadillac Hotel in Detroit, June 4, 5, 6, 1956. The Michigan State Medical Society made a contribution to aid in staging this congress.

The program was divided into many sections and had a number of Michigan participants. A Symposium on Cancer of the Prostate included "Criteria of Operability in Prostatic Cancer," with six participants including Reed Nesbit, M.D., of Ann Arbor, who was also part of a nine-member panel on "Therapy for Disseminated Prostatic Cancer." "Cancer of the Gastrointestinal Tract" was considered in five sections. "Lymphomas of the Gastrointestinal Tract" was presented by Frederick A. Collier, M.D., Ann Arbor, and William Eiller, M.D., Henry Ford Hospital, Detroit.

Cancer of the Lung was discussed under the titles: "Are Viruses Etiological Agents in Cancer?" "Incidence of Lung Cancer," "Etiology of Lung Cancer." "Environmental Aspects" was presented by Arthur J. Vorwald, M.D., Detroit. A part of the discussion panel was Robert C. Horn, Jr., M.D., Detroit. Carl V. Weller, M.D., Ann Arbor, took part in the panel discussion on "Management of Lung Cancer," taking the pathological aspects. "Cancer of the Female Genital Tract" had Harry M. Nelson, M.D., of Detroit on the planning committee, also as chairman of the "Mass Screening Methods for Detection of Cancer of the

(Continued on Page 866)

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References: 1. Hollander, J. L., Ann. New York Acad. Sc. 61:511, May 27, 1955.

2. Hollander, J. L., et al. J.A.M.A. 158:476, June 11, 1955.



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## NEWS MEDICAL

(Continued from Page 864)

Cervix." He also reported on "Results of Screening Asymptomatic Patients for Uterine Cancer." Norman F. Miller, M.D., Ann Arbor, presented "An Analysis of the Results of Treatment in State I of Carcinoma of the Cervix." In "Cancer of the Head, Evaluation of Treatment Failures," Isadore Lampe, M.D., Ann Arbor, considered "The Tongue."

The seventieth Annual Clinic Day and Alumni Reunion of the Wayne University College of Medicine Alumni occurred May 8 and 9, 1956. The attendance was unusually high and the program outstanding. The opening assembly was led by Dean Gordon Scott with introductory remarks. Gordon B. Myers, M.D., Professor and Chairman of the Division of Medicine, presented "Treatment of Cardiac Failure." Charles G. Johnston, M.D., Professor and Chairman of the Division of Sur-



Wilfrid H. Haughey, M.D., receiving the 1956 Wayne University Alumni Award from University President, Clarence B. Hilberry.



Duncan J. McColl, M.D., receiving the 1956 Wayne University Alumni Award from University President, Clarence B. Hilberry.

Wayne University Alumni Association held its 88th reunion and banquet Saturday, May 26, 1956, at the Sheraton-Cadillac Hotel in Detroit. Over 700 attended. Following a stated program, speeches were made by officers and the president of the University, Clarence B. Hilberry. The University for the seventh time awarded Distinguished Service Awards. Each year not more than one Doctor of Medicine has been so honored, but this year two were chosen. The list was Albert Earl Blashfield, Michigan Bar President and Editor of *Michigan State Bar Journal* and *Wisconsin Bar Journal*; Walter Leonard Couse, Past President, Association of General Contractors of America; Wilfrid Haughey, M.D.; Duncan John McColl, M.D.; and Clarence Raymond Wiley, Jr., Professor and Chairman of the Department of Mathematics, University of Utah.

Dr. Haughey, a member of the Wayne University class of 1906, is Editor of *THE JOURNAL* of MSMS, President of Michigan Medical Service (Blue Shield) and a trustee of the Wayne University Medical Library. Special recognition was given to Dr. Haughey for his research in leukemia and spasmodic asthma.

Dr. McColl, who was graduated from Wayne University in 1893, was honored for his lifelong service in the practice of medicine and for the honor bestowed upon him by MSMS as "Michigan's Foremost Family Physician" in 1954.

gery, discussed "The Problem of Intestinal Obstruction." The afternoon program included: "The Clinical Use of Present-Day Insulins" by R. B. Leach, M.D., Assistant Professor of Medicine; "Ganglionic Blocks in the Treatment of Hypertension" by Yoshikazu Morita, M.D., Instructor in Medicine; "Treatment of Anemia," by George O. Clifford; "Value of Hormone Therapy in the Rheumatic Diseases" by Alfred Jay Bellett, M.D., Assistant Professor of Medicine; Management of Colles' Fractures" by Paul K. Truba, M.D., Assistant Professor of Surgery; "The Spinal Oblique Fracture of the Tibia" by A. Jackson Day, M.D., Clinical Assistant Professor in Orthopedic Surgery; "Pathological Fractures" by Herbert E. Pedersen, M.D., Senior Instructor in Orthopedic Surgery; "Diverticulosis of the Colon" by Don W. McLean, M.D., Clinical Assistant Professor of Surgery; "Carcinoma of the Colon" by Gaylord S. Bates, M.D., Clinical Assistant Professor of Surgery; "Neoplasms of the Chest" by Robert T. Crowley, M.D., Assistant Professor, New York University; "Injuries of the Chest" by Paul V. O'Rourke, M.D., Clinical Assistant Professor of Surgery; "Fluid Balance Management in Burns" by Warren O. Nickel, M.D., Assistant Professor of Surgery; "Local Treatment of Burns" by George L. Walker, M.D., Clinical Assistant Professor of Surgery; "Prevention of Pre-eclampsia," by Harold L. Fachnie, M.D., Assistant Professor of Obstetrics and

(Continued on Page 868)

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1. Pollock, B. E., and Pruitt, F. W.: *Am. J. M. Sc.*, 226:172, 1953.

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(Continued from Page 866)

Gynecology; "Detection and Treatment of Cervical and Uterine Carcinoma" by Charles S. Stevenson, M.D., Professor and Chairman of the Division of Obstetrics and Gynecology; "Obstetrical Analgesia and Anesthesia" by Ralph F. Sertor, M.D., Fellow in the Department of Gynecology; "Management of Leukorrhea and Vulvar Pruritus" by Charles D. Darling, M.D., Clinical Instructor. There was also a symposium on "Acute Conditions of the Abdomen," Moderator Osborne A. Brines, M.D., Professor of Pathology, Alfred M. Large, M.D., Clinical Assistant Professor of Surgery; Muir Clapper, M.D., Professor of Medicine; Charles S. Stevens, M.D., and Robert M. Whitlock, M.D., Assistant Professor of Surgery.

Wednesday, May 9, the Alumni Reunion program was held at Hotel Fort Shelby. At the annual alumni business meeting, Don W. McLean, M.D., was installed as President and Osborne S. Brines, M.D., was made President-Elect. The scientific program was unusually well selected and presented:

#### Morning Session

##### "The Treatment of Coronary Heart Disease"

A. CARLTON ERNSTENE, M.D., Cleveland, Ohio  
Chief of Staff, Division of Medicine, Cleveland Clinic

##### "The Choice of Treatment of Hypothyroidism"

E. PERRY McCULLAGH, M.D., Cleveland, Ohio  
Head of the Department of Endocrinology and Metabolism, Cleveland Clinic

##### "Modern Methods in Psychiatric Therapy"

JACQUES S. GOTTLIEB, M.D., Detroit, Michigan  
Director of the Lafayette Clinic, Detroit  
Professor of Psychiatry, Wayne University College of Medicine

#### End of Morning Session

#### Noon Program

##### Subscription Luncheon—Coral Room

##### "Technique of Preparing Medical Articles for Publication"

GEORGE E. STILWELL, M.D., Mayo Clinic  
Section of Publications, Mayo Clinic  
Member of the Board of Editors of the *American Journal of Clinical Pathology and Minnesota Medicine*

##### "Diagnosis and Treatment of Carcinoma of the Larynx, Bronchi and Esophagus"

CHEVALIER L. JACKSON, M.D., Philadelphia, Pennsylvania  
Professor of Laryngology and Broncho-Esophagology, Temple University

##### "Problems in Pediatric Surgery"

ORVAR SWENSON, M.D., Boston, Massachusetts  
Surgeon in Chief of Boston Floating Hospital for Infants and Children, New England Medical Center  
Associate Professor of Surgery, Clinical Professor of Pediatric Surgery, Harvard Medical School

The evening session was the annual alumni banquet with more than 200 in attendance. An Honorary Membership in the Association was presented in *absentia* to Honorable Albert E. Cobe. The class of 1956 was introduced, with response by Calier Worrel, '56. The Medical Alumni Sophomore Scholarship Award went to Jerald R. Creteau, '58; and the Medical Alumni Senior Scholarship award was won by Harold D. Partney, '56.

(Continued on Page 870)

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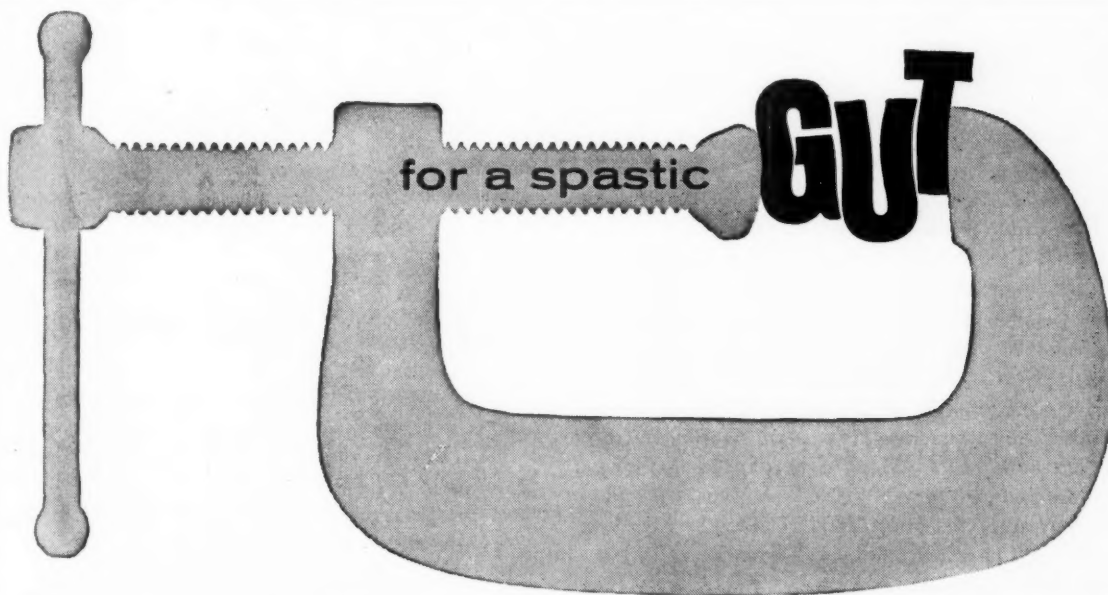
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JULY, 1956

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## NEWS MEDICAL

(Continued from Page 868)

Distinguished Service Citations were presented to John S. DeTar, M.D., '31, and Roger V. Walker, M.D., '19.

The Golden Anniversary Reunion of the Class of 1906 was, as always, the feature of the entire program. The class originally graduated eighty-three members.

August 25, 1956, for diabetic children in a controlled regime. A competent staff directs the camp, and a physician and nurse are always in attendance. Facilities necessarily limit registrations to fifty children.

Further information may be obtained by contacting: Director, Camp Midicha, 1120 Maccabees Bldg., Detroit, or TE 1-3750.



Ten members of the Class of 1906, who received Golden Diplomas.  
*Top Row* (left to right).—John F. McKay, Grand Forks, N. D.; Walter A. DeFoe, Richmond, Indiana; Wilfrid Haughey, Battle Creek; Raymond L. Clark, Detroit; Floyd L. Covert, Gaines; Claude H. Smith, Dearborn.  
*Bottom Row* (left to right).—Ford M. Sommerville, Oil City, Pa.; Fred E. Stevens, Detroit; Alexander W. Blain, Detroit; James L. Hammond, Escondido, California.

Ten of the class attended the reunion and were given Gold Diplomas: Walter A. DeFoe, Richmond, Ind.; Alexander W. Blain, Detroit; Floyd L. Covert, Gaines; Raymond L. Clark, Detroit; Wilfrid Haughey, Battle Creek; James L. Hammond, Escondido, Calif.; John F. McKay, Grand Forks, N. D.; Claude A. Smith, Dearborn; Fred E. Stevens, Detroit; Ford M. Summer-ville, Oil City, Pennsylvania.

Irwin W. Sanders, who presented the diplomas, gave a short résumé of each doctor's accomplishments. It was surprising that so few have fully retired. Response was made by Alexander W. Blain, president of the class at graduation. Seven of the class were unable to attend, some on account of illness or disability: Andrew D. Potter, Maidstone, Ontario; Henry A. Ott, Detroit; Charles K. Boyajian, Sherman Oaks, Calif.; Lomen L. Harrison, Niles, Michigan; Wilbur J. Voorheis, Orlando, Florida; Thomas C. Starrs, Detroit, and Oscar H. Arndt, Detroit.

Six members of the class could not be located, although the University has made extensive enquiry.

\* \* \*

**Camp Midicha**, a camp for diabetic children, sponsored by the Michigan Diabetes Association, provides fun and health for boys and girls from six to fourteen. The camp is located at Columbiaville about 65 miles north of Detroit, and will be open from August 12 to

**The Pan-Pacific Surgical Association** will hold its Seventh Congress in Honolulu, November 14-22, 1957. All members of the Medical profession are cordially invited to attend and are urged to make early arrangements. An outstanding scientific program by leading surgeons with sessions in all divisions of surgery and related fields will be offered. For information, write Dr. F. J. Pinkerton, Director General of the Pan-Pacific Surgical Association, Room 230, Young Building, Honolulu, Hawaii.

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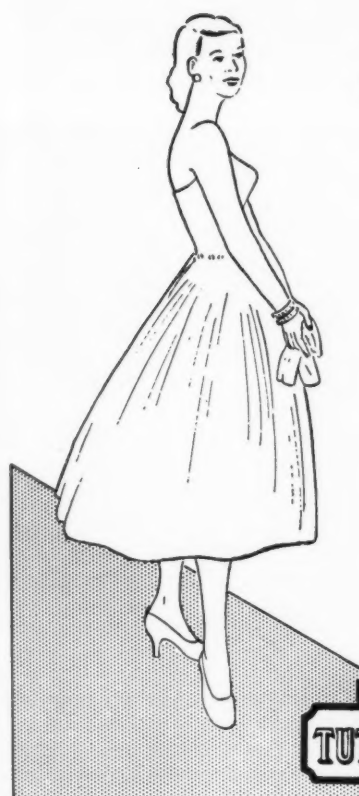
**The Michigan Diabetes Association** will sponsor a summer camp for diabetic children from August 12 to August 25 at the Tau Beta Camp in Columbiaville, Michigan. Diabetic children on a controlled regime and in the age group, six to fourteen, will be accepted. For information, write Director, Camp Midicha, 1120 Maccabees Bldg., Detroit.

\* \* \*

**The Post-Graduate Medical School of New York University-Bellevue Medical Center** will hold a full-time, eight-week comprehensive course in occupational medicine September 10 through November 2. For information, write Dean, New York University Post-Graduate Medical School, New York 16, N. Y.

\* \* \*

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 (Continued on Page 872)



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| Methyl para hydroxybenzoate          | 7.0 mg. | Succinic acid | 15.0 mg. |
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## NEWS MEDICAL

(Continued from Page 870)

with the University of Havana School of Medicine, will hold the first inter-American Conference on Occupational Medicine and Toxicology, September 3-7 in Miami. For program, write Dr. Homer F. Marsh, Dean of the School of Medicine, University of Miami.

\* \* \*

The American College of Obstetricians and Gynecologists is the new name of the American Academy of Obstetrics and Gynecology. Headquarters are at 116 South Michigan Avenue, Chicago 3, Illinois. Among the officers are the following men from Michigan: Norman F. Miller, M.D., Ann Arbor, First Vice President; C. Paul Hodgkinson, M.D., Birmingham, Secretary; and Harold C. Mack, M.D., Detroit, Chairman of District V.

\* \* \*

The Census Bureau estimated the United States population on April 1 at 167,440,000, an increase of 16,308,000 since April 1, 1950.

\* \* \*

Parke, Davis and Company, Detroit, has announced publication of a new periodical, *Pediatric Patterns*, which will enable physicians to determine the incidence of communicable diseases in any given area. The periodical will include last-minute reports on poliomyelitis, diphtheria, streptococcal infections, measles and whooping cough.

More than 250 physicians attended the recent meeting of the Michigan Chapter of the American Academy of General Practice held in Detroit. Shown in the photo-



graph are: (left to right) Russell F. Fenton, M.D., Detroit, President of the Michigan Chapter of the American Academy of General Practice; Fred C. Brace, M.D., Grand Rapids, President of the Western Michigan Chapter; William L. Rodgers, M.D., Grand Rapids; Stanley Moleski, M.D., President of the Kent County Medical Society; and F. P. Rhoades, M.D., Detroit.

(Continued on Page 874)



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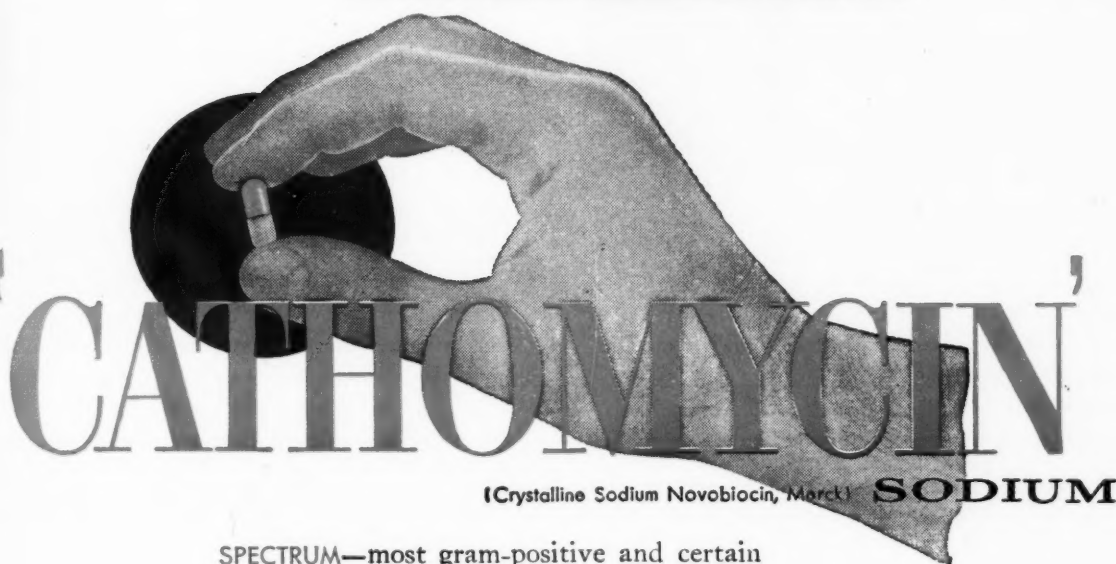
**PROVED EFFECTIVE AGAINST**

**SPECIFIC ORGANISMS**

(*staphylococci and proteus*)

**RESISTANT TO ALL OTHER**

**ANTIMICROBIAL AGENTS**



**SPECTRUM**—most gram-positive and certain gram-negative pathogens.

**ACTION**—bactericidal in optimum concentration even to resistant strains.

**TOXICITY**—generally well tolerated. This is more fully discussed in the package insert.

**ABSORPTION**—oral administration produces high and easily-maintained blood levels.

**INDICATIONS**—cellulitis, pyogenic dermatoses, septicemia, bacteremia, pneumonia and enteritis due to *Staphylococcus* and infections involving certain strains of *Proteus vulgaris*; including strains resistant to all other antibiotics.

**DOSAGE**—four capsules (one gram) initially and then two capsules (500 mg.) twice daily.

**SUPPLIED**—250 mg. capsules of 'CATHOMYCIN', bottles of 16.

'CATHOMYCIN' is a trademark of Merck & Co., Inc.



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DIVISION OF MERCK & CO., INC.

(Continued from Page 872)

The 10th General Assembly of The World Medical Association will be held in Havana, Cuba, October 9-15. For information, write Dr. Louis H. Bauer, 10 Columbus Circle, New York 19, New York.

\* \* \*



Otto O. Beck, M.D., Birmingham, will serve as Chairman of Arrangements for the 1957 Michigan Clinical Institute, Sheraton-Cadillac Hotel, Detroit, March 13-14-15, 1957.

Wm. M. LeFevre, M.D., Muskegon, is serving as Chairman of the Program Committee for the 1957 Michigan Clinical Institute.



\* \* \*

Lawrence Reynolds, M.D., Detroit, has been awarded the honorary degree of Doctor of Laws by Wayne University, Detroit.

Congratulations, Doctor Reynolds!

The Mississippi State Medical Association Centennial opened on May 7 with the dedication of a new \$150,000 central office headquarters building, containing 4,400 square feet of office space. The white ribbon stretched across the entrance was jointly cut by Elmer Hess, M.D., of Erie, Pennsylvania, President of the American Medical Association, and by S. Lamar Bailey, M.D., of Kosciusko, Mississippi, President of the Mississippi Association. The new Mississippi Medical Association headquarters building is in the heart of a growing medical center. The Mississippi Association membership now exceeds 1,300.

\* \* \*

Basic Science.—The State of Michigan now has waiver with seventeen states of the twenty-one having basic science laws (in 1953, Michigan had the privilege of waiver with only one state). The improvement is due to changes in the Basic Science Act made at the Michigan Legislative Session of 1955. This has made it easier for applicants coming from other states to be certified in Michigan.

\* \* \*

AMA Closes Printing Plant.—The last issue of *The Journal AMA* to roll off the AMA's own printing plant presses was that of June 30. Hereafter, *The Journal* will be printed by the McCall Corporation of Dayton, Ohio, which has been printing *Today's Health*. The AMA has owned its own printing establishment for seventy years, but the AMA headquarters building is no longer big enough to house both the printing plant and

(Continued on Page 876)

## IF YOUR PATIENT WANTS TO DRINK THAT'S HIS BUSINESS IF HE WANTS TO QUIT that's our BUSINESS

BRIGHTON HOSPITAL, now in operation for over 2 years, wishes to thank the physicians of Michigan and Ontario for the good reception and the confidence given to us.

We know that today's physician recognizes the many-sided nature of the disease—Alcoholism. Beyond the physical, which requires expert treatment in itself, the alcoholic's physician is plagued, we know, with the equally vital aspects, which make demands on his time and attention, of the emotional, spiritual and mental sickness he notes in his patient.

We believe that Brighton Hospital offers the answer. Physicians can now send their alcoholic patients to Brighton with the certain assurance that they will find expert medical

and nursing attention AND that, if they so desire, patients will be thoroughly indoctrinated with the program of Alcoholics Anonymous.

BRIGHTON HOSPITAL is NOT interested in the patient who merely wishes to be dried out in order to resume drinking. We ARE interested in those patients who really, fervently, seek complete rehabilitation and a way of life FREED from alcohol.

BRIGHTON HOSPITAL is owned and operated by MICHIGAN ALCOHOLIC REHABILITATION FOUNDATION, a non-profit organization devoted to the best possible hospitalization of the alcoholic who seeks to stop drinking.

DOCTORS, we are here to serve you. We are here to serve your patients.

# BRIGHTON HOSPITAL

12851 East Grand River Avenue

Brighton, Michigan

Phone: Brighton Academy 7-1211



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Recommended by Eminent Michigan Physicians

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BUY...**

**Sealtest**  
DAIRY PRODUCTS

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Say you saw it in the Journal of the Michigan State Medical Society

(Continued from Page 874)

the Association's many other activities. Other departments will immediately take over the first three floors and basement of the building (71,357 square feet).

\* \* \*

Kinescopes of the first two "Grand Rounds" closed-circuit television programs produced earlier this year by the Upjohn Company of Kalamazoo have been released for showing before any group in the medical or allied professions, and require only a 16 mm. sound projector.

"Acute Abdominal Problems," an hour-long film of the January 18 program, deals with a variety of conditions and features a panel of eminent clinicians, including Charles G. Child, M.D., Orvar Swenson, M.D., and Harold F. Rheinlander, M.D., of Tufts University; Walter L. Palmer, M.D., University of Chicago; Leo G. Rigler, M.D., and Owen H. Wangenstein, M.D., University of Minnesota.

The second film, "The Cardiac Patient in Stress: Work, Surgery, Pregnancy," is one and one-half hours in length. Participating clinicians include: Paul Dudley White, M.D., Merrill C. Sosman, M.D., Samuel A. Levin, M.D., and C. Sidney Burwell, M.D., of Harvard University; and Samuel Proger, M.D., and Benjamin Etsten, M.D., of Tufts University.

Arrangements for local showing of these two kinescopes may be made through the Upjohn Company headquarters in Kalamazoo or local Upjohn representatives.



Our peripatetic President Wm. S. Jones, M.D., has had more than one unusual experience during his travels about the State. Between visits to the Allegan County Medical Society in Allegan and the Gratiot-Isabella Clare County Medical Society, Mount Pleasant he took time to sweep through Ludington with Mr. Hugh W. Brenneman to talk to the Lions Club, Optimist Club, visit the hospital, tape a radio broadcast, talk to the medical society and visit the newspaper and radio station offices. The picture shows him presenting the Optimist Creed to the Optimist Boy-of-the-Month in Ludington. Doctor obviously enjoyed this duty.

\* \* \*

MSMS President William S. Jones, M.D., of Menominee, still holds justifiable pride in his native state of Georgia, in spite of some thirty-five years of practice in Michigan's Upper Peninsula. This loyalty was rewarded when Dr. Jones was made an honorary member of the Georgia State Medical Society while attending its annual meeting in Atlanta, May 10 and 11. Dr. Jones was born near Jeffersonville, Georgia. He attended the 1956 Georgia State Medical Society meeting as official representative of MSMS.

## Doctor:

*Your earning power is your most valuable asset*

Insure against loss of income through the Michigan State Medical Society's comprehensive group accident and sickness insurance plan—

This is the worthy disability program approved by your State Society. The Provident's personal representative (for Michigan exclusively) will contact you at the invitation of the Michigan State Medical Society.

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The Award  
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## NEWS MEDICAL

O. T. Mallery, Jr., M.D., Ann Arbor, Chairman of The Award Committee of the Industrial Medical Association, recently presented an award "for health achievement in industry" to the Pennsylvania Railroad at the Association's annual banquet in Philadelphia.

\* \* \*

Wayne University College of Nursing is in the midst of a recruiting program for students for its thirty-two-week training course for psychiatric aides, the second class of which will begin in September. The College is emphasizing the need for male psychiatric aides but is accepting applications from both men and women, eighteen to fifty years old.

This new program—first of its type in the United States—was inaugurated last January. Training includes both classroom instruction and carefully supervised practice in caring for mental patients at Northville State Hospitals. A certificate of achievement is presented to trainees upon completion of their course. Then the College of Nursing and Michigan Department of Mental Health review the record of each trainee for final job placement.

\* \* \*

The American Board of Obstetrics and Gynecology on May 20, 1956 certified the following Michigan physicians following this year's examinations: Norman L. Banghart, M.D., Ann Arbor; Samuel J. Behrman, M.D., Ann Arbor; Charles J. Berger, M.D., Birmingham; Edmond S. Bosch, M.D., Ann Arbor; Fred B. Gray, M.D., Grand Rapids; Arthur R. Hummell, M.D., Detroit; Perry E. Prather, M.D., Saginaw; James M. Riekse, M.D., Grand Rapids; John T. Rogers, M.D., Detroit; James H. Tisdell, M.D., Port Huron; Robert F. Trescott, M.D., Lansing; Clarence F. Webb, M.D., Grand Rapids and Joseph B. Woolfenden, M.D., Detroit.

\* \* \*

The nineteenth edition of the AMA Directory (for 1956) was delivered early in June. It was a tremendous undertaking, occupying the entire efforts of a large staff in the headquarters building. It lists 240,638 Doctors of Medicine in its 3,122 pages. Six years have elapsed since the last AMA Directory was published. There were over 250,000 address changes during the interval, 24,225 doctors have died, and 46,348 new names have been added.

In Michigan, there are listed 7,900 Doctors of Medicine, of these, 5,571 are members of the American Medical Association through the Michigan State Medical Society; eighty-five are members in Michigan but not of the AMA. There are 2,082 general practitioners listed; 790 indicate special interest in some specialty; 2,296 limit their practice to a specialty, and 1,653 have certificates of their specialty boards. A total of 1,491 are interns or house physicians, and 612 are in other full-time hospital service. There are 177 in government service, 222 are not in practice, and 270 are listed as retired.

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WHO SUFFERS  
IN THE  
MENOPAUSE  
DESERVES  
"PREMARIN"  
*widely used  
natural, oral  
estrogen***

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JULY, 1956

Say you saw it in the Journal of the Michigan State Medical Society

877

NEWS MEDICAL

DOCTOR LOCATIONS  
Through June 1, 1956

| Placed by Michigan<br>Health Council:<br>Name                  | Opened<br>Practice in | Approximate<br>Date | From             |
|--|-----------------------|---------------------|------------------|
| Grant Garlock, M.D.<br>Assisted by Michigan<br>Health Council: | Jackson (Prison)      | April 1956          | Minnesota        |
| Thomas Lindman, M.D.   | Flint                 | April               | Chicago          |
| Stanley Michael, M.D.  | Schoolcraft           | July 1              | Flint internship |
| Richard Rusak, M.D.  | Standish              | July 1              | Saginaw          |
| Donald Archibald, M.D.   | White Pines           | June 1              | Detroit          |
| Charles Schoff, M.D.   | Midland               | June 1              | Williamston      |

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Interpretation of Cervico-Vaginal, Etc.  
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for the

Diagnosis of Carcinoma

Kits (Slides, Spatulas, Fixative and  
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Instructions for Taking and Mailing  
Smears furnished on request

M. WM. RUBENSTEIN, M.D.

GYNE-CYTOLOGY LABORATORY

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organomercurial diuretics  
"...permit ingestion of  
enough salt to make food  
palatable; without them,  
many patients would lose  
their appetites, a conse-  
quence of the salt-free diet  
which has occasionally been  
known to cause serious  
malnutrition."\*

\*Modell, W.: The Relief of Symptoms, Phil-  
adelphia, W. B. Saunders Company, 1955,  
pp. 265-266.

03156

SOCIAL SECURITY DISABILITY FREEZE

(Continued from Page 780)

there is consultation among physicians in any  
borderline situation.

Guides to Filling Out the Medical Report Form

No matter how good the standards, or how  
considered the judgment of the reviewing team,  
the determination reached can be no sounder than  
the evidence upon which it is based. To make  
sure that he is providing sufficient medical evi-  
dence for a prompt and fair determination, the  
doctor will want to consider the following guides  
in filling out medical report forms for those of his  
patients who have applied for the social security  
disability freeze:

1. Include sufficient clinical detail to enable  
the reviewing team to make a sound determination  
as to the severity and extent of the patient's  
current condition;
2. Give enough of the clinical history to pro-  
vide information as to when the disability began,  
and when it became so severe as to keep the  
patient from working;
3. Describe the probable course of the con-  
dition from now on, so that a decision can be  
reached as to whether the impairment is likely to  
continue indefinitely, or end in death, or whether  
it is self-limiting, or remediable in the foreseeable  
future.

In 1940, when Blue Cross paid \$27,000 for the hos-  
pital care given 455 new mothers and their babies,  
maternity cases comprised less than three per cent of  
all members hospitalized. In 1955, the 103,230 mater-  
nity cases represented one of every five Blue Cross ad-  
missions.

## Communications

Dear Dr. Haughey:

I have your letter of May 18, 1956, concerning the Air Force firepower demonstration which was held at Eglin Air Force Base, Florida, last month. I had the good fortune to be invited to witness this spectacle as a guest of Maj. Gen. Robert E. L. Eaton, Commander of the 10th Air Force.

This experience is most difficult to describe in words, but we did find the trip a gratifying and unforgettable experience. We departed from Selfridge Air Force Base and returned two days later. The entire expedition was conducted with the efficiency and precision which has made our Air Force famous. We were fortunate in stopping over to visit the electronics training center at Keesler Air Force Base, Mississippi. The training program for the some ten thousand students presently in the school is by far the most elaborate and most efficient training program which I have ever observed.

The mission of the Air Proving Ground Command is to conduct operational suitability tests of tactically equipped aircraft, materiel, or equipment with its component systems and support items to determine its tactical suitability. These tests include tactical evaluation and will develop under simulated and actual combat and climatic conditions, improved operational tactics and techniques. These tests further develop and refine support and training requirements. Without undue interference with the primary purpose of these tests, additional data on functional development is collected. As a result of these tests, this command makes recommendations to Headquarters USAF on the type classification of aircraft

(manned or pilotless) and equipment systems (or major components of either) which, though on the ground, are operating in conjunction with airborne aircraft; and, in the case of ground equipment systems or major components thereof essential to the aircraft mission, determines and takes final type classification action based on evaluation of logistical suitability, functional suitability, and operational suitability.

It is also the responsibility of the Air Proving Ground Command to conduct aerial firepower demonstrations at Eglin Air Force Base and to plan, co-ordinate, and supervise all other major aerial demonstrations in the United States.

The Air Proving Ground Command encompasses an area of 800 square miles, or approximately one-half million acres. In addition to the main base at Eglin there are ten auxiliary fields. Included in the reservation are 40 rocketry and gunnery ranges and a water range that extends 70 miles along the coast and 170 miles into the Gulf of Mexico.

The Climatic Hangar, large enough to accommodate the B-36 Intercontinental bomber, issued to conduct climatic testing of all types of equipment utilized by the Air Force. The Climatic Hangar operates within a temperature range of plus 170° to minus 65° Fahrenheit, and has been an invaluable adjunct to actual cold weather tests conducted in Alaska and Greenland.

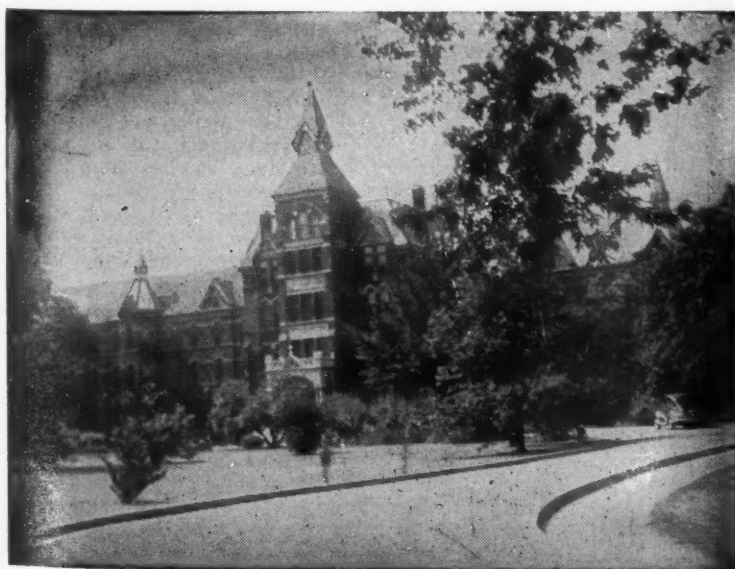
The Air Proving Ground Command is not confined to this geographical area, however. The world is its proof test area, and permanent detachments of the command are located in other areas within this country and in the Far East and Europe.

Perhaps the greatest resource within the Air Proving Ground Command are the men in the machines and the men behind the machines.

Here are gathered some of the finest pilots in the Air Force, backed by experienced maintenance crews and technically trained personnel skilled in applying

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## Cook County Graduate School of Medicine

INTENSIVE POSTGRADUATE COURSES  
STARTING DATES—SUMMER & FALL, 1956

**SURGERY**—Surgical Technic, two weeks, August 6, September 17  
Surgical Anatomy and Clinical Surgery, two weeks, October 1  
Surgery of Colon and Rectum, one week, September 17  
General Surgery, one week, October 22  
Thoracic Surgery, one week, October 1  
Esophageal Surgery, one week, September 24  
Breast and Thyroid Surgery, one week, October 22  
Gallbladder Surgery, three days, October 29  
Fractures and Traumatic Surgery, two weeks, October 15

**GYNECOLOGY & OBSTETRICS**—Obstetrics and Gynecology, three weeks, October 22  
Office and Operative Gynecology, two weeks, September 17  
Vaginal Approach to Pelvic Surgery, one week, September 10

**MEDICINE**—Electrocardiography and Heart Disease, two week basic course, October 8; one week advanced course, September 17

Internal Medicine, two weeks, September 24  
Gastroscopy and Gastroenterology, two weeks, September 10

Gastroenterology, two weeks, October 22

Dermatology, two weeks, October 15

Cardiology (Pediatrics), two weeks, November 5

**RADIOLOGY**—Diagnostic X-Ray, two weeks, September 17  
Clinical Uses of Radioisotopes, two weeks, October 8

**UROLOGY**—Two-week course, October 8  
Cystoscopy, ten days, by appointment

**TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL**

ADDRESS: REGISTRAR, 707 South Wood Street, Chicago 12, Illinois

physical resources. Together, they form an ideal team for assessing the operational suitability of the latest Air Force weapons and equipment.

Two kinds of testing are done at APGC: (1) operational suitability testing to determine whether new equipment is capable of performing the mission for which it was designated under all foreseeable conditions of use, and (2) testing of new tactics and operational procedures so that the personnel who eventually use the new equipment can do so with knowing, capable hands.

When the APGC takes over an aircraft, for example, it has been proven as a flying machine only. Earlier testing is done by the Air Research and Development Command to make certain that the aircraft fully meets design specifications, but its capabilities in the field are still unknown and must be proven by test personnel in this northwest Florida Proving Ground.

Eglin Air Force Base, headquarters and only permanent command installation, is an ideal laboratory for testing aircraft and other weapons of air warfare. It is isolated, spacious (approximately 465,000 acres), offering such varied terrain as sea-coast, hill-country, and heavily forested plain. The nucleus of this vast territory was donated by an air-minded citizen of Florida, the late James E. Plow, and the remainder was once the Choctawhatchoo National Forest. Dotted with ten auxiliary airfields and numerous bombing and gunnery ranges, the area affords test officers opportunity to set up simulated combat problems under differing conditions, at the same time leaving a wide margin of safety for the protection of civilians living in surrounding localities. Relations with nearby communities are good as these Floridians realize that the mock battles performed in the sky over the former hunting grounds of the Seminole Indians are necessary for the preservation of their way of life.

Those battles—under conditions as close to those of actual combat as imagination and skill can make them—are held with USAF pilots alternately in the roles of attacker and defender, and occasionally with a pilotless drone as a predestined victim. Experienced combat pilots gather data as they fly not only to evaluate the aircraft being tested but to provide future pilots with reliable information concerning its characteristics and methods of employment in training and combat.

When an aircraft has been thoroughly tested in its temperate phase, tests at extremes of temperature begin. For this the plane is taken to Eglin's Climatic Hangar, a triumph of engineering skill that is an integral part of the natural and man-made test laboratory facilities at the disposal of the Air Proving Ground Command. The main chamber of the hangar is 200 by 250 feet, large enough to accommodate a B-36 Intercontinental bomber and several smaller planes at the same time. The temperature in this chamber can be lowered to sixty-five degrees below zero in less than forty-eight hours, then raised to 165 above. It contains bomb pits, landing gear actuator stands, ports for running jet engines and firing guns. Short of actual flight, there is little about a plane's performance that cannot be tested in the hangar.

Perhaps the main value of the hangar is that of safety for Air Force pilots and crews. Weather performance data gathered while an aircraft is stationary in the hangar is important knowledge when the plane is tested in flight under naturally severe climatic conditions. It gives test officers an opportunity to know about engine performance, stability of controls and reliability of fuel systems in an aircraft before they trust their lives to it.

Although the Climatic Hangar tests are as complete as science can make them, they cannot be finally conclusive since they do not include flight. A detachment must still be sent to Ladd Air Force Base near the Arctic Circle in Alaska. Missions flown at Ladd are similar to those flown at Eglin during the temperate

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today  
than they have been  
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4 F-84F's

4 F-100's

F-89D

CF-100

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F-89C

F-84F

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JULY,

COMMUNICATIONS

phase—they are planned to test the aircraft's ability to do the job for which it was designed. But there is one great difference: the winter temperature at Ladd often sinks as low as sixty below and remains for days at a time. There is little about a plane's performance at low temperatures that cannot be determined in day-to-day operations under such rigorous conditions.

The Air Proving Ground Command at Eglin Air Force Base is under the command of Maj. Gen. Robert W. Burns, USAF. The tests and demonstrations were conducted flawlessly and with amazing precision. Some of the more spectacular demonstrations included in the missions were as follows:

| Aircraft Type       | Munitions  | Description of Mission   |
|---------------------|--|--|
| 4 F-84F's           | None   | Thunderbird precision flying demonstration                           |
| 4 F-100's           | None   | Supersonic boom from level flight                                    |
| F-89D               | 104 2.75" rockets with flash heads   | Air-to-air rocket demonstration                                      |
| CF-100              | 56 2.75" rockets with flash heads  | Air-to-air rocket demonstration                                      |
| 4 F-86H's           | 2 fire bombs per acft  | Formation fire bomb attack on factory target                         |
| F-89C               | 50 rockets from T-110 gun  | Strafing simulated enemy aircraft                                    |
| F-84F               | 2 napalm bombs; 2 250-lb. bombs; 28 2.75" rockets; cal. .50 guns with API and tracer | Display of fighter versatility. All-out effort by one fighter-bomber |
| 3 F-100's           | 1000-lb GP bomb, each aircraft.  | Demonstration of 60°, 90°, and 110° toss bombing technique           |
| B-57                | One 1000-lb. bomb  | Demonstration of toss bombing technique, 45°                         |
| B-57                | Eight rocket pods (56 2.75" rockets); five 500-lb. incendiary bombs with chutes      | Night tactical bomber attack on marshalling yards                    |
| B-66B               | Seven 750-lb. bombs  | Demonstration of newest tactical bomber                              |
| KB-50 and 3 F-100's | None   | Demonstration of probe and drogue type of in-flight refueling        |
| B-52                | Napalm air burst   | Simulated A-bomb burst   |
| B-36                | Maximum load of 500-lb. bombs  | Demonstration of bombing capability                                  |

Many of these demonstrations were new and thrilling to me. It was certainly a great thrill to see the air disturbance around the plane when the sound barrier was broken and to feel the force of the supersonic boom which followed.

Many of us have witnessed the development of flight, electronics, and nuclearphysics in our generation. One cannot help but be alarmed by the destructive potential of our modern weapons. We can take some comfort in the realization that our preparedness and de-

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90th Year of Continuous Service

Ideal for Executives. Rest combined with medical supervision and a physical examination.

Diagnostic and therapeutic service. Special Departments in Physical Therapy including Hydro and Mechanotherapy, Electrotherapy, Heliotherapy, Radiotherapy and Massage.

Well suited for treatment of metabolic disorders, hypertension, obesity, arthritis and degenerative diseases generally. All Sanitarium care is under the immediate guidance of qualified physicians.

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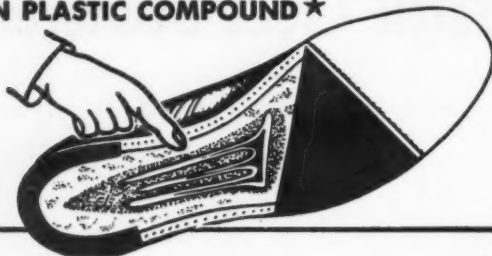
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● We are also the manufacturer of the Gear-Action Shoe designed by noted orthopedic surgeon.

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A Division of Musebeck Shoe Company

"...in patients  
with moderately  
severe and severe  
cardiac failure,  
neohydrin  
is the oral diuretic  
of choice."\*

\*Moyer, J. H., and others:

J. Chronic Dis. 2:670, 1955.

01056

fensive strength have reached such a high degree of development. I personally hope that the existence of these forces make their wartime use unthinkable and improbable.

Detroit, Michigan  
June 4 1956

Sincerely yours,  
LAWRENCE A. PRATT, M.D.

\* \* \*

Mr. William J. Burns,  
Executive Director  
Michigan State Medical Society  
Dear Bill:

As you know, we conducted our first conference for attorneys representing state and county medical societies in Chicago on April 19-20. From all reports, the meeting was a real success and since this was our first attempt of this kind we are very happy.

I wanted to write to you and tell you that the success of the meeting was due primarily to the caliber of the men that appeared on the program. The contribution that was made by Joe Herbert was one of the highlights of the two-day meeting. I have already written to him and thanked him; however, I also wanted you and the officers of your association to know what a good job he did. I hope that you will express our appreciation to the proper people for permitting him to participate.

Best personal regards,  
C. JOSEPH STETLER, Director  
Law Department  
American Medical Association

## Legal Opinions

Dear Mr. Burns:

You have referred to me for opinion the inquiry of a certain County Medical Society Secretary, concerning post-mortem examinations by county coroners.

Specifically, the Secretary asks, "What is the legal authority and responsibility of our coroners in ordering autopsies and is the prosecuting attorney or the board of supervisors at all involved?"

The powers and duties of county coroners are purely statutory. They differ in counties having a population less than 250,000 from those that are larger. In any event, however, we must find the answers in the statute law, there being no common law governing the coroner.

The duty or authority to hold post-mortem examinations by direction of the county coroner is to be found in a section of the Code of Criminal Procedure entitled "Proceedings for the Discovery of Crime." These provisions differ but little from those which have been on our statute books for several decades. There are other statutory references to the duties of the coroner which are somewhat of lesser importance. Among them is the provision in the statute concerning vital statistics (M.S.A. 14.228) which reads as follows:

"In case of any death occurring without medical attendance it shall be the duty of the undertaker or person acting as such to notify one of the county coroners, or a justice of the peace acting as coroner, who shall investigate or hold an inquest as to the cause of such death on the death certificate and shall sign the same officially as coroner or acting coroner. If such death was the result of violence, the said coroner, or justice of the peace acting as such, shall state the cause of the violence and whether or not it was apparently accidental, suicidal or homicidal and shall furnish such further information as may be required by the state commissioner of health."

It is to be noted, however, that under this section the coroner is to make either an investigation or an

## LEGAL OPINIONS

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inquest "as the circumstances require." If an inquest, it must be as set forth in the Criminal Code, Chapter XIII, being M.S.A. 28.1169 to 28.1191.

The specific reference is to be found in Sec. 4 of the Chapter, being M.S.A. 28.1172. The significant portion thereof states as follows:

"\* \* \* Provided, That in all cases it shall be lawful for the magistrate holding any such inquest, to require by subpoena the attendance of a competent physician or surgeon for the purpose of making a post-mortem examination and of testifying as to the result of the same; and he may also employ a chemist in cases affording reasonable ground of suspicion that death has been produced by poison and the amount of compensation for the attendance and services of such physician, surgeon or chemist shall be audited and allowed by the board of supervisors of the proper county, or board of county auditors in counties having such board."

No authority is granted by statute for a coroner to direct a post-mortem examination other than that contained in the section of the Criminal Code referred to above.

The question as to whether a coroner, even though he be a doctor of medicine, is authorized or permitted to perform a post-mortem examination, except in the course of a formal inquest, is discussed in an opinion of the Attorney General given in 1915 to A. M. Wilkin-son, M.D., then coroner of Charlevoix County. The opinion in part reads as follows:

"I note from your communication of recent date that you hold the office of coroner in Charlevoix County and that some question has arisen as to your authority to perform post-mortem examinations in certain cases. The precise point at issue is whether or not such an examination may be made by you in your official capacity as coroner without an inquest being held, compensation therefor being made by the county.

"The statute does not seem to contemplate any such procedure as you suggest. Section 11831 of the Compiled Laws of 1897 empowers a coroner who conducts an inquest to summon a competent surgeon or chemist when the attendance of such is deemed necessary. This statute must, I believe, be taken to imply that a post-mortem examination is not to be made by, pursuant to the direction of, a coroner except where a formal inquest is held. It will be noted also that the statute does not empower the coroner himself to make such an examination. \* \* \* It seems to me, therefore, that in a case falling within the jurisdiction of a county coroner if the circumstances surrounding the death are of a suspicious character and such as in the judgment of the coroner demand an examination including a post-mortem, an inquest should be held and the provisions of the statute with reference to procuring a surgeon or chemist should be observed."

### Report of Attorney General 1916, p. 216.

It is, of course, well known that the inquest to which reference is made is authorized only upon such persons as shall have come to their death suddenly or by violence. This, however, is not the type of case to which the Society seems to have reference.

It is my opinion that except pursuant to a statutory inquest in cases where suspicion of crime is involved, that is death by violence or poison, there is no statutory authority, much less any duty, for the coroner to order a post-mortem examination.

As to the question of what part the prosecuting attorney may have in this connection, reference is had to M.S.A. Sec. 28.1189 which reads as follows:

"Where, in the discretion of the prosecuting attorney, an inquest is deemed necessary, the coroner upon written order of the prosecuting attorney, shall summon six (6) men all of whom shall be citizens of the United States, residents of the county, and shall administer the oath as provided for by this chapter except that the jurors need not view the body of the deceased."

In construing this provision the Attorney General in an opinion dated May 22, 1946, number 0-4658, held in substance as follows: Although the prosecuting attorney has no specific statutory authority to order an autopsy if he determines a need for it on discovery of crime, the reasonable expense incurred thereby, such as the charge for services of a pathologist performing it, is a just claim against the county, since the prosecuting attorney may incur such expenses as are immediately necessary for the investigation and discovery of crime, subject to audit and allowance by the board of auditors.

It is to be observed that this power of the prosecuting attorney relates itself to formal inquests for the purpose of discovery of crime and not merely for the determination of the cause of death in other types of cases.

The supervisors appear to have no statutory authority to direct the coroner to cause post-mortem examinations to be made in cases other than those provided for by statute. The fee of the physician who makes the autopsy and testifies at the statutory inquest is to be audited and allowed by the board of supervisors, as indicated by the section above cited, (M.S.A. 28.1172). There is no statute which authorizes a board of supervisors to pay for post-mortem examinations under other circumstances.

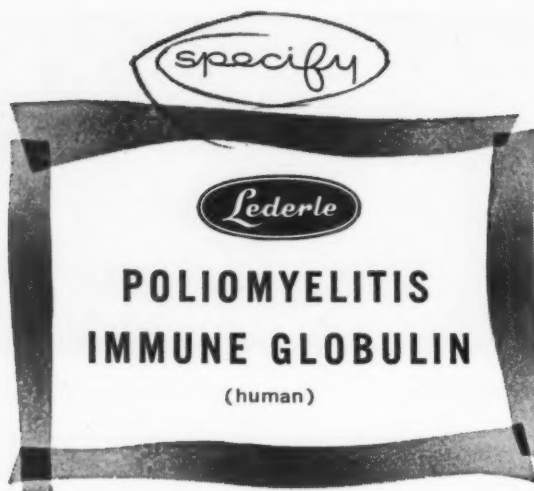
In conclusion, it is my opinion that the coroner may not be compelled to conduct or to direct autopsies merely for the purpose of ascertaining the cause of death, except in cases where formal inquests are authorized. Formal inquests may not be had except when crime or violence is suspected.

Very truly yours,  
J. JOSEPH HERBERT  
Legal Counsel

May 15, 1956

JULY, 1956

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## DIRECTIONS OF PSYCHIATRY

(Continued from Page 810)

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cation include an emphasis on family practice and  
on the effects which the individual's way of life  
and his interpersonal relationships have on his  
health. Leaders in medical education are pretty  
well agreed that the practice of medicine must em-  
brace the attitudes of the old family physician,  
fortified with the findings of modern science.

Psychiatry, because of its interest in the patient  
as a person, is in an excellent position to bind  
together the various departments of modern medi-  
cine so that there can be a complete approach  
to the problems of the individual. It should be  
taught as a basic science in our medical schools  
and co-ordinated with other branches of medicine  
so that students may be familiarized with the  
emotional problems that will loom so large in  
their daily practice.

In the exhilaration we may well feel at the  
advances of psychiatry and at the fact that it  
may serve as the cornerstone of comprehensive  
medicine, let us never forget our own inter-  
dependencies, our own deficits, and our own  
specific mission as ministers unto minds diseased.  
Let us say, as did Roger Bacon seven hundred  
years ago:

"All sciences are connected; they lend each other  
material aid as parts of one great whole. . . . As an  
eye torn out or a foot cut off, so it is with the different  
departments of knowledge; none can attain its proper  
result separately, since all are part of one and the same  
complete wisdom."

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#### BOOKS RECEIVED

**NEW AND NONOFFICIAL REMEDIES.** Containing descriptions of drugs evaluated by the Council on Pharmacy and Chemistry of the American Medical Association. 1956. An annual publication issued under the direction and supervision of the Council. Philadelphia and Montreal: J. B. Lippincott Company, 1956.

**COMMUNITY PROGRAMS FOR MENTAL HEALTH.** Theory—Practice—Evaluation. Editors: Ruth Kotinsky, Helen L. Witmer. Advisory Committee: Abraham Z. Barhash, M.D.; Jules V. Coleman, M.D.; Sibylle Escalona; Katherine E. Faville; George E. Gardner, M.D.; Paul V. Lemkau, M.D.; W. Carson Ryan; Mildred C. Scoville. Contributors: Barbara Biber; H. E. Chamberlain; Sol W. Ginsburg; Robert R. Holt; Louisa P. Howe; Marie Jahoda; Elizabeth de Schweinitz; Edith Miller Tufts. Cambridge, Massachusetts: Harvard University Press, 1955.

**A DICTIONARY OF DIETETICS.** By Rhoda Ellis, Ph.D. Instructor of Foods and Nutrition Department of Home Economics, Brooklyn College, New York. New York: Philosophical Library, 1956. Price, \$6.00.

**THE TRUTH ABOUT CANCER.** By Charles S. Cameron, M.D., Medical and Scientific Director of American Cancer Society; with a preface by Elmer Hess, M.D., Erie, Pennsylvania, President of the American Medical Association. 300 pages. Englewood Cliffs, N. J.: Prentice-Hall, 1956. Price, \$4.95. (All proceeds—royalties—go to American Cancer Society.)

This interesting volume is for the layman. The basic material is written so that it is readily understood by laymen. Some of the fascinating theories and facts about civilization and cancer are revealed. The volume is a highly readable book of twenty-four chapters, with fifty illustrations. The eminent author systematically explains causes, misconceptions, diagnosis, treatment, research and the classes of cancer.

"The Truth About Cancer" has an excellent chapter on quackery—which alone is worth investment in this worthy addition to cancer literature. The volume is a

scientifically complete and accurate statement of the cancer problem in all its phases—sanely optimistic. The latest authoritative medical facts are presented simply and in an enlightening manner. The "Truth About Cancer" offers hope for saving twice as many lives as are now being saved. It has just to be read!

W.J.B.

**SYMPOSIUM ON EXPERIMENTAL TUBERCULOSIS BACILLUS AND HOST WITH AN ADDENDUM ON LEPROSY.** Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Margaret P. Cameron, M.A., A.B.L.S., assisted by Cecilia M. O'Connor, B.Sc. 69 illus. Boston: Little, Brown and Company, 1955. Price, \$9.00.

This book presents the proceedings of the symposium held on experimental tuberculosis, sponsored by the Ciba Foundation, an educational and scientific charity established under the laws of England and operated independently by a Board of Trustees. These proceedings are published in full with a minimum of editing, and presents the informal discussions of the current and incomplete research in tuberculosis by a group of leading scientists, with Professor Arnold Rich of Johns Hopkins University, serving as chairman. The conference did not deal with the clinical aspects of tuberculosis, but concentrates its attention on the constitution and properties of the tubercle bacillus, which endow it with the capacity to act as it does in the body.

Several chapters are devoted to the chemical structure of the tubercle bacillus and the effect of these bacterial components in stimulating reaction in the various tissues. Other chapters contain many stimulating informal discussions and arguments on such current topics as the mode of action of cortisone on the pathogenesis of tuberculosis, the mechanism involved in acquired immunity, the relationship between the growth requirements and the pathogenicity of isoniazid resistant mutants of tubercle bacilli and the role of bacterial multiplication in the establishment of immunity to tuberculosis. This book is highly recommended for the tuberculosis specialist and is a "must" for the scientist doing basic research in the field.

Included in the book is an addendum on experimental leprosy, which is included because of the pathogenic relationship between tuberculosis and leprosy.

S. A. YANNITELLI, M.D.

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**A COURSE IN PRACTICAL THERAPEUTICS.** By Martin Emil Rehfuss, M.D., F.A.C.P., LL.D. (Hon), Professor of Clinical Medicine, Emeritus, and Director of the Division of Therapeutics in the Department of Medicine, the Jefferson Medical College, Philadelphia; Attending Physician, the Jefferson Medical College Hospital, Philadelphia. Alison Howe Price, A.B., M.D., Associate Professor of Medicine, The Jefferson Medical College, Philadelphia; Assistant Physician to the Jefferson Medical College Hospital, Philadelphia; Chief Clinical Assistant Diabetic Clinic, Curtis Clinic, Philadelphia. Third Edition. Baltimore: The Williams & Wilkins Company, 1956. Price \$15.00.

With the continuous development of new methods in treatment, more potent remedies, more specialized treatment and the introduction of an astounding number of drug preparations, the busy physician (and student) is in need of a complete and concise reference work which avails him of the simplest form of modern treatment of diseases. The third edition of this book, written in outline form, is worthy of its whole-hearted acceptance as a medium through which this need can be achieved.

The scope and content of this volume embraces a unique attempt to correlate clinical medicine with applied therapeutics. Inference is made that good therapy depends on accurate diagnosis, and throughout the volume differential diagnoses are presented as much as possible.

The volume is divided into four broad sections entitled "General Therapeutic Principles," "Symptomatic Therapy," "Treatment of Specific Disorders," and "Special Treatment." The Table of Contents is complete and detailed, permitting reference to any section or subsection without difficulty.

This is a concise, inclusive, easy to read, and magnificently illustrated book, with diagrams and schematic charts which serve to make it eminently practical.

#### STATE DEPARTMENT OF SOCIAL WELFARE

(Continued from Page 831)

If he fails to use the total amount, his allotment will be reduced.

This method of medical care provision has been found to be quite satisfactory and has reduced the total amount spent in most counties where tried. About half of the counties are now under the new program and the balance of the state will be included beginning July 1, with gradual change-over until October 1, when the whole state including Wayne County will be operating under the new regulations.

Much more care is expected to be rendered to the patients, and a savings *in toto* accomplished. If, in certifying to Form SB-54A, the doctors are realistic, it is hoped all monies will actually be spent for medical care.

The provision of dental care for aid to de-

pendent children cases is now receiving careful consideration. Amounts of care and costs are unknown quantities, but rules of relief and requirements are being established. Permission is being sought from federal departments to experiment in certain restricted areas to determine needs and costs.

Over a two-year period, Michigan State Medical Society committees have interested themselves in these problems. We are happy to report great progress has been made in simplification of forms and procedures.

#### ANNUAL REPORT OF CHILD WELFARE COMMITTEE—1955-1956

(Continued from Page 851)

driver training examinations. They also stressed the need for general education that infants with obvious eye defects get early attention.

The Subcommittee on School Health Problems studied the possibility of standardized health examinations and forms for these examinations, school health councils, and closer affiliation with the Michigan School Health Association.

The Committee wishes to express its appreciation for the co-operation of the Michigan Department of Health and will continue to serve to the best of its abilities in advising Michigan State Medical Society on current child welfare problems.

Respectfully submitted,

R. M. HEAVENRICH, M.D., *Chairman*  
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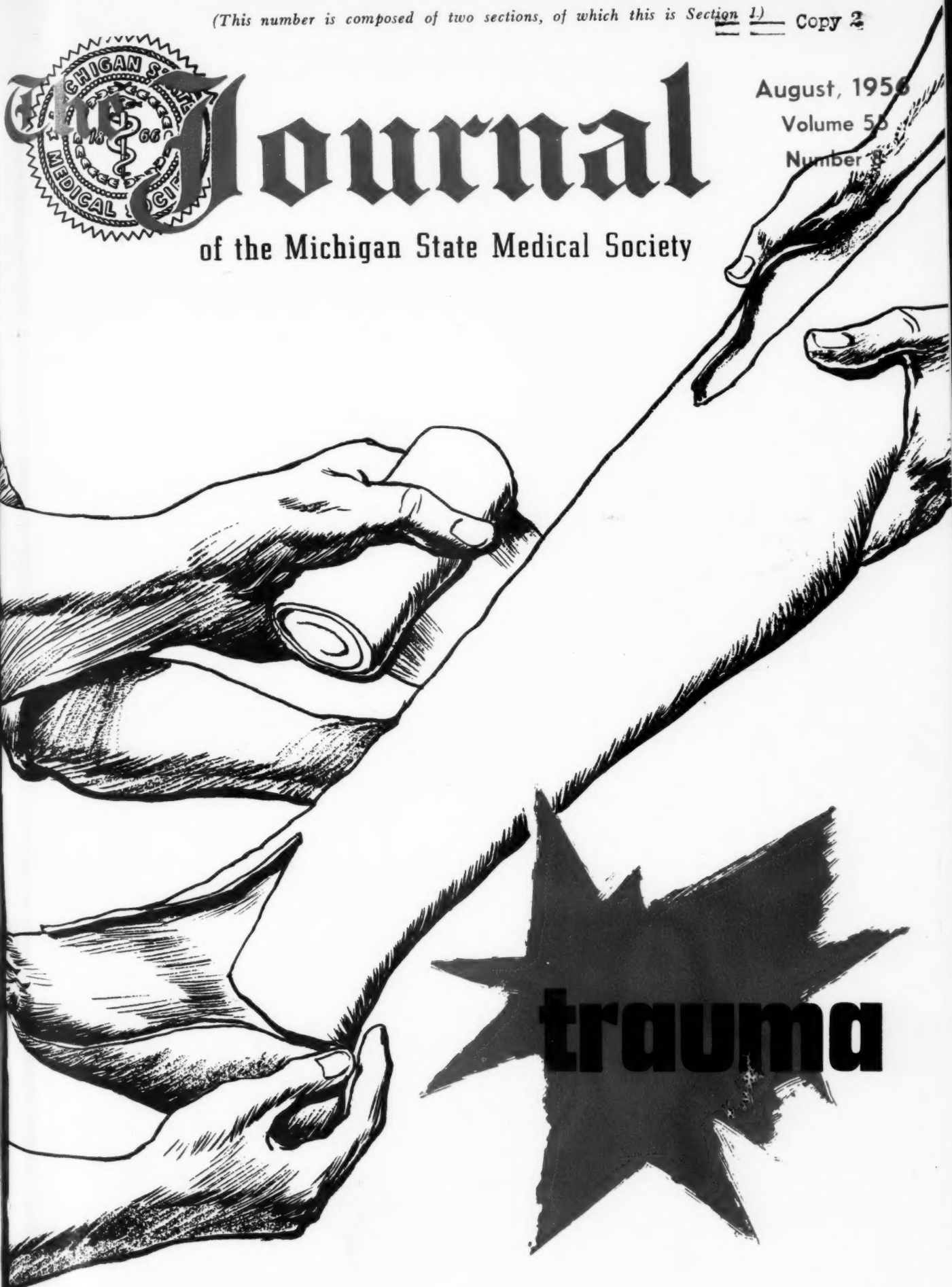
# Journal

of the Michigan State Medical Society

August, 1956

Volume 53

Number 3



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August

# THE JOURNAL of the Michigan State Medical Society

VOLUME 55

AUGUST, 1956

NUMBER 8

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# THE JOURNAL

## of the Michigan State Medical Society

VOLUME 55

AUGUST, 1956

NUMBER 8

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All communications regarding advertising and subscription should be addressed to Wm. J. Burns, 2642 University Avenue, Saint Paul 14, Minnesota, or 606 Townsend Street, Lansing 15, Michigan. Telephone Ivanhoe 57125.

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| <b>Pediatrics</b><br>Bernard Bernbaum, M.D.....Detroit<br>Chairman<br>C. E. Booher, M.D.....Grand Rapids<br>Secretary  |   | <b>Occupational Health</b><br>C. D. Selby, M.D.....Port Huron<br>Chairman<br>O. J. Johnson, M.D.....Bay City<br>Secretary                   |
| <b>Delegates</b><br>W. A. Hyland, M.D., Grand Rapids, Chairman.....1957<br>W. D. Barrett, M.D., Detroit.....1956<br>J. S. DeTar, M.D., Milan.....1957<br>W. H. Huron, M.D., Iron Mountain.....1956<br>R. L. Novy, M.D., Detroit.....1956<br>C. I. Owen, M.D., Detroit.....1957 | <b>DELEGATES TO A. M. A.</b><br>G. W. Slagle, M.D., Battle Creek.....(1) 1956<br>William Bromme, M.D., Detroit.....(2) 1956<br>J. R. Rodger, M.D., Bellaire.....(3) 1956<br>W. W. Babcock, M.D., Detroit.....(1) 1957<br>E. F. Sladek, M.D., Traverse City.....(2) 1957<br>O. J. Johnson, M.D., Bay City.....(3) 1957 | <b>Alternates</b>   |

### Section Delegate

G. C. Penberthy, M.D. (Surgical Section).....Detroit

**EMERGENCY!**

in acute episodes  
of senile agitation

**THORAZINE\***  
produces a prompt,  
dramatic calming effect

'Thorazine' is available in ampuls, tablets and syrup, as the hydrochloride; and in suppositories, as the base.

'Thorazine' should be administered discriminately and, before prescribing, the physician should be fully conversant with the available literature.

*always carry 'Thorazine' Ampuls in your bag*

*Smith, Kline & French Laboratories, Philadelphia*

\*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

in inflammatory skin diseases



all the benefits of the "predni-steroids"  
plus positive antacid action  
 to minimize gastric distress

ROUTINELY ACHIEVED WITH

**'Co-Deltra'**  
 (Buffered Prednisone)



Multiple  
Compressed  
Tablets

**'Co-Hydeltra'**  
 (Buffered Prednisolone)



MERCK SHARP & DOHME  
 DIVISION OF MERCK & CO., INC.  
 PHILADELPHIA 1, PA.

Clinical evidence<sup>1,2,3</sup> indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al*, *J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al*, *J.A.M.A.* 158:459, (June 11,) 1955.

2.5 mg. or 5 mg.  
 prednisone or  
 prednisolone with  
 50 mg. magnesium  
 trisilicate and  
 300 mg. aluminum  
 hydroxide gel.

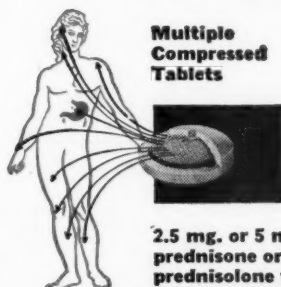
'CO-DELTRA' and 'CO-HYDELTRA' are the trademarks of MERCK & CO., INC.

in bronchial asthma

clinical evidence<sup>1,2,3</sup> indicates that to augment the therapeutic advantages of the "predni-steroids" antacids should be routinely co-administered to minimize gastric distress

**ROUTINE  
CO-ADMINISTRATION  
MEANS**

**'Co-Hydeltra'**  
(Buffered Prednisolone)



Multiple  
Compressed  
Tablets

**'Co-Deltra'**  
(Buffered Prednisone)

All the benefits of the "predni-steroids" plus positive antacid action to minimize gastric distress.

References: 1. Boland, E. W., J.A.M.A. 160:613, (February 25,) 1956. 2. Margolis, H. M. et al, J.A.M.A. 158:454, (June 11,) 1955. 3. Bollet, A. J. et al, J.A.M.A. 158:459, (June 11,) 1955.

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.



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# You and Your Business

## NEW OFFICERS' NIGHT BANQUET—SEPTEMBER 26

A sparkling innovation at the 1956 MSMS Annual Session will be the Officers' Night Banquet, to be held Wednesday evening, September 26, at 7 P.M. in the Grand Ballroom of the Sheraton-Cadillac Hotel, Detroit.

Sponsored by the State Society and its Woman's Auxiliary, the subscription banquet will be in lieu of the annual dinner of The Council and the Woman's Auxiliary Banquet. These two affairs will thus be unified and expanded so that all members of the Michigan State Medical Society and their ladies may take advantage of an excellent opportunity for a gay evening of good fellowship and pleasure.

The Officers' Night Banquet will be informal. Invitations to all members, giving detailed information on the interesting program, will be mailed in August. Tables may be reserved in groups of ten. Individual reservations also are invited.

## EXPANSION OF RHEUMATIC FEVER PROPHYLACTIC PROGRAM

Effective June 1, 1956, payment of a fee to doctors of medicine for administration of benzathine penicillin G in their offices to children who have had rheumatic fever but who have not had a previous court order will be made by the Crippled Children Commission under certain conditions of hardship. It may have been that previous care was provided by hospital insurance or by other agencies, or it may be that economic circumstances have changed.

The Crippled Children Commission will accept for this purpose only a certificate from the physician on a special form furnished by the Commission bearing the following information:

1. Identification of child and physician.
2. First and second attacks of rheumatic fever—where treated, by whom, and when.
3. A definite statement as to presence or absence of heart disease with manifestations if the former.
4. Diagnosis—New York Heart Association Nomenclature preferred.
5. A definite statement that third-party payment will be necessary to insure uninterrupted prophylaxis unless gratuitous service is rendered.
6. A definite statement under the signature of the responsible relative that participation is desired and that financial inability exists.
7. A definite request for authorization to bill the Michigan Crippled Children Commission for prophylactic treatment.

## HOMETOWN MEDICAL CARE PROGRAM CONTINUED

H. V. Higley, Veterans Administrator, officially informed the President of the Michigan State Medical Society, W. S. Jones, M.D., of Menominee, in a letter dated June 13, 1956—"We will continue our arrangement in Michigan for the Veterans Hometown Medical Plan."

In his communication, Administrator Higley explained several other factors, one which is the matter of economy. "At the present time," stated Mr. Higley, "we are trying to make certain that the figure at which we have arrived is somewhat in keeping with what it would cost to do the work ourselves, and you may recall there was quite a divergence between the charges being made by the several states still operating a plan similar to the Michigan one."

The action of Administrator Higley assures for Michigan veterans a continuation of the personal medical care of their own practitioners of medicine in their own communities. Free choice of doctor and hospital again has been retained!

## VA PSYCHIATRIC AND NEUROLOGIC FEES CHANGED

The Veterans Administration, early in July, notified Michigan Medical Service of the following changes in the VA Hometown Medical Care Program so far as psychiatric and neurological care is concerned:

### EXAMINATIONS BY SPECIALISTS

|       |  |        |
|-------|--|--------|
| 0039A | Major portion of each additional half-hour ..... | \$5.00 |
| 0040A | Major portion of each additional half-hour ..... | 5.00   |

### OUT-PATIENT TREATMENT BY SPECIALISTS

|       |  |      |
|-------|--|------|
| 0054A | Major portion of each additional half-hour ..... | 5.00 |
|-------|--|------|

### AMENDMENT IN DESCRIPTIONS AND FEES EXAMINATIONS BY SPECIALISTS

|      |  | New<br>Fee | Old<br>Fee |
|------|--|------------|------------|
| 0039 | Examination by Psychiatrists to determine diagnosis..... | 15.00      | 10.00      |
| 0040 | Examination by Neurologists to determine diagnosis.....  | 15.00      | 10.00      |

### OUT-PATIENT TREATMENTS BY SPECIALISTS

|       |  |       |      |
|-------|--|-------|------|
| 0053  | Psychiatric treatment up to first half-hour..... | 7.50  | 5.00 |
| 0053A | Major portion of each additional half-hour ..... | 7.50  | 5.00 |
| 0054  | Neurologic treatment .....                       | 10.00 | 5.00 |

The new fees will be applicable only to those services authorized and rendered on and after the effective date, July 1, 1956.

(Continued on Page 898)

## BETTER

results are obtained with STERANE<sup>1</sup>—3 to 5 times more active than hydrocortisone or cortisone.

## BREATHING

capacity is greatly enhanced. "Relief of symptoms is more complete and maintained for longer periods with relatively small doses."<sup>2</sup>

## BALANCE

of minerals and fluids usually remains undisturbed. This proves "especially advantageous in those patients with cardiac failure requiring therapy..."<sup>3</sup>

in bronchial asthma

# Sterane<sup>®</sup>

brand of prednisolone

Supplied : White, 5 mg. oral tablets, bottles of 20 and 100. Pink, 1 mg. oral tablets, bottles of 100. Both deep-scored.

1. Johnston, T. G., and Cazort, A. G.: J. Allergy 27:90, 1956. 2. Schwartz, E.: New York J. Med. 56:570, 1956. 3. Schiller, I. W., et al.: J. Allergy 27:96, 1956.

**PFIZER LABORATORIES**  
Division, Chas. Pfizer & Co., Inc.  
Brooklyn 6, New York



(Continued from Page 896)

**HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL****Meeting of June 20, 1956**

- **Governor's Study Commission on Prepaid Hospital Care Plans**—Mr. George Bowles, Chairman, had reported the possibility that the forthcoming study may be broken into three segments, each to be given to a separate department of the University of Michigan, all to be corrected by some agency (such as the Brookings Institution)—under the supervision of a special committee of the U of M Regents.
- **M. H. Marks, M.D.**, Detroit, was appointed chairman and P. A. Martin, M.D., Detroit, and H. B. Zemmer, M.D., Lapeer, as members of a special MSMS liaison committee to the Michigan Society of Neurology and Psychiatry and the Michigan Psychological Society.
- **Committee Reports**—The following were given consideration: (a) Michigan Cancer Co-ordinating Committee, meeting of May 17; (b) Rural Medical Service Committee, May 17; (c) Committee on Michigan Medical Service, May 23; (d) Committee on Postgraduate Medical Education, May 24; (e) Program Committee for 1957 Michigan Clinical Institute, June 7; (f) Child Welfare Committee, June 7; (g) Committee on Study of Prevention of Highway Accidents, June 7; (h) Committee on Study of Healing Arts, June 11; (i) Rheumatic Fever Control Committee, June 13; (j) Health and Accident Insurance Policy Control Committee, June 19; (k) Hospital Relations Committee, June 19.
- **Committee personnel** for the year 1956-57 was presented by President-elect Arch Walls, M.D., for publication in the Handbook for Delegates.
- **G. B. Saltonstall, M.D.**, was appointed chairman of the March 14, 1957, Testimonial Luncheon honoring Michigan presidents of National Medical Associations (held coincident with the Michigan Clinical Institute).
- **B. L. Masters, M.D.**, Fremont, was appointed official representative to attend AMA Conference of Chairmen of State Medical Society Rural Health Committees, October 19, 20 at Purdue University.
- **IBM Billing Procedure**—Progress report on changeover in MSMS billing from Kardex to the electronic system, as of January 1, 1957, was made by the Executive Director, who was instructed to notify all county society secretaries of this change.
- **V. G. Chabut, M.D.**, of Northville, and John R. Rodger, M.D., of Bellaire, were thanked for their attendance and reports on, respectively, the 5th National Conference on Physicians and Schools, and the Regional Conference on Traffic Safety.

- **Report on AMA House of Delegates' Session** of June, 1956, was presented by William A. Hyland, M.D., Chairman of AMA Delegation.
- **"Officers' Night" Banquet**, September 26, 1956, in Detroit, during MSMS Annual Session. Recommendation of Woman's Auxiliary that a subscription banquet be held on the Wednesday evening of the 1956 Annual Session in Detroit was approved; the Woman's Auxiliary was invited to assume the responsibility for arranging this function.
- **Legal Counsel's progress report** on Koppasch case: In June, the Circuit Court found that Dr. Koppasch's amended bill of complaint was indefinite and hazy and the plaintiff was instructed to amend the complaint or his pleading will be stricken.
- **R. W. Waggoner, M.D.**, Ann Arbor, was appointed Chairman with Z. Steven Bohn, M.D., Detroit, and J. Joseph Herbert, M.D., Manistique, as members of a committee to study the problem of care of the mentally disturbed to avoid hospitalization.
- **Poliomyelitis Vaccine Distribution**.—Report on action taken by the State Advisory Committee on Poliomyelitis Vaccine Distribution was presented by K. H. Johnson, M.D., Lansing, a member of this governmental committee.

**AMEF CHAIRMAN FOR MICHIGAN**

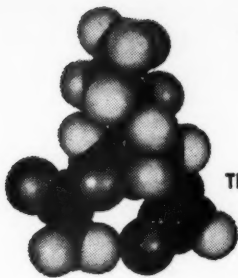
Donald J. Jaffar, M.D., of Detroit, is the new Michigan Chairman for the American Medical Education Foundation, the national fund through which doctors of medicine are able to support American medical schools.

Dr. Jaffar is Associate Professor of Urology and acting head of the department at Wayne State University College of Medicine, and attending Urologist and acting head of the department at the Detroit Receiving Hospital. He is also president of the staff at Providence Hospital and attending urologist there.

Dr. Jaffar is a diplomate of the Board of Urology, Fellow of the American College of Surgeons, and active in a number of regional and national medical and specialty organizations.

A resident of Detroit since 1913, he has practiced in that city since completing his internship and residency at the University Hospital, Ann Arbor, following his graduation from University of Michigan Medical School in 1928. Dr. Jaffar has been associated with Wayne State University and the Detroit Receiving Hospital since 1930.

(Continued on Page 902)



THE MILTOWN MOLECULE

**A tranquilizer well suited for prolonged therapy**

**NO ORGANIC  
CONTRAINDICATIONS**

**reported to date**

- well tolerated, non-addictive, essentially non-toxic
- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness
- chemically unrelated to chlorpromazine or reserpine
- does not produce significant depression
- orally effective within 30 minutes for a period of 6 hours

**Indications: anxiety and tension states, muscle spasm.**

**Miltown<sup>®</sup>**

THE ORIGINAL MEPROBAMATE

DISCOVERED AND INTRODUCED by Wallace Laboratories, New Brunswick, N. J.



2-methyl-2-n-propyl-1,3-propanediol dicarbamate—U. S. Patent 2,724,720

SUPPLIED: 400 mg. scored tablets. Usual dose: 1 or 2 tablets t.i.d.

*Literature and Samples Available on Request*

Combined for a  
ON  
resistant

*new*  
**METRETON** *tablets*

*METICORTEN (PREDNISONE) PLUS CHLOR-TRIMETON WITH ASCORBIC ACID*

*For prompt and effective relief, especially in many resistant allergic disorders, METRETON affords the benefits of two established agents with unexcelled anti-inflammatory, anti-allergic and antipruritic effectiveness. supported by essential vitamin C—for stress support and for postulated effect on prolonging steroid action no better corticosteroid—original brand of prednisone...minimal electrolyte effects—METICORTEN no better anti-histamine—unexcelled in potency and freedom from side effects—CHLOR-TRIMETON effective against hay fever, pollen asthma, perennial rhinitis, acute and chronic urticaria, angioneurotic edema, drug reactions, inflammatory and allergic eye disorders, pruritic and contact dermatoses.*

*formula:* Each tablet of METRETON provides 2.5 mg. of METICORTEN (prednisone), 2 mg. of CHLOR-TRIMETON maleate (chlorprophenpyridamine maleate), and 75 mg. ascorbic acid.

*supplied:* METRETON Tablets, bottles of 30 and 100.

frontal attack

allergies

*new*

## METRETON *Nasal spray*

METICORTEONE (PREDNISOLONE) PLUS CHLOR-TRIMETON

quickly clears nasal passages • avoids rebound engorgement and sympathomimetic side effects • safe even for cardiacs, hypertensives, children, pregnant patients •

**Composition:** Contains 2 mg. (0.2%) METICORTEONE acetate (prednisolone acetate) and 3 mg. (0.3%) of CHLOR-TRIMETON gluconate (chlorphenpyridamine gluconate) in each cc.

**Packaging:** 15 cc. plastic "squeeze" bottle, box of 1.

METRETON,\* brand of corticoid-antihistamine compound; METICORTEN,\* brand of prednisone; METICORTEONE,® brand of prednisolone; CHLOR-TRIMETON,® brand of chlorphenpyridamine preparations. \*T.M.

MT-J-576

*Schering*



(Continued from Page 898)

INSURANCE INDEMNITY PAID

L. Fernald Foster, M.D.  
Bay City, Michigan

Re: Provident Life and Accident Insurance Co.  
Dear Doctor:

This is a note to the members of the Michigan State Medical Society Committee on Health and Accident Insurance Policy Control.

I should like to inform the members of this committee of the fact that a recent claim of mine with regard to disability was given special consideration and a full indemnity was paid even though the company was under no legal obligation to do so.

I would recommend continuation of our contract with the Provident Life and Accident Insurance Company.

Yours very truly,

M.D., Detroit

June 18, 1956

MEDICAL EDUCATION

In 1955, eighty-one approved medical schools enrolled more than 28,000 students and graduated almost 7,000 physicians. Twenty-five years ago, there were seventy-six approved schools that enrolled less than 22,000 students and graduated less than 5,000 physicians. This year there are eighty-two approved schools of medicine, and by 1960 there will be at least eighty-five such institutions.

Since 1910, there has been a 120 per cent increase in the number of graduating physicians and a 128 per cent increase in medical school enrollment, as compared with an 80 per cent increase in the total population of the United States.—Editorial, JAMA, April 21, 1956.

organomercurial diuretics  
"...permit ingestion of  
enough salt to make food  
palatable; without them,  
many patients would lose  
their appetites, a conse-  
quence of the salt-free diet  
which has occasionally been  
known to cause serious  
malnutrition."\*

\*Modell, W.: The Relief of Symptoms, Philadelphia, W. B. Saunders Company, 1955, pp. 265-266.

03156

DUES AND SPECIAL ASSESSMENTS OF  
STATE MEDICAL ASSOCIATIONS

| State                     | Dues  | Special Assessments | Comments  |
|---------------------------|-------|---------------------|---|
| Alabama .....             | \$ 20 | —o—                 | Dues \$50.00 effective 1/1/57   |
| Arizona .....             | 60    | —o—                 | Dues \$70.00 effective 1/1/57—extra \$10.00 for AMEF                        |
| Arkansas .....            | 25    | —o—                 |   |
| California .....          | 50    | —o—                 |   |
| Colorado .....            | 50    | —o—                 |   |
| Connecticut .....         | 28    | \$10**              |   |
| Delaware .....            | 50    | —o—                 |   |
| District of Columbia..... | 50    | —o—                 |   |
| Florida .....             | 40    | —o—                 |   |
| Georgia .....             | 25    | —o—                 |   |
| Idaho .....               | 40    | —o—                 |   |
| Illinois .....            | 40    | —o—                 |   |
| Indiana .....             | 30    | —o—                 |   |
| Iowa .....                | 60    | —o—                 | \$ 25 increase authorized; not yet levied                                   |
| Kansas .....              | 40    | —o—                 |   |
| Kentucky .....            | 35    | —o—                 |   |
| Louisiana .....           | 50    | —o—                 |   |
| Maine .....               | 60    | —o—                 |   |
| Maryland .....            | 50*   | —o—                 |   |
| Massachusetts .....       | 30†   | —o—                 |   |
| Michigan .....            | 35    | —o—                 |   |
| Minnesota .....           | 45    | \$10 (1956)         |   |
| Mississippi .....         | 40    | —o—                 | Dues increased \$5 each for three years; 1957, \$40; 1958, \$45; 1959, \$50 |
| Missouri .....            | 35    | —o—                 |   |
| Montana .....             | 25    | \$10 (1957)         |   |
| Nebraska .....            | 53    | —o—                 |   |
| Nevada .....              | 35    | —o—                 |   |
| New Hampshire .....       | 100   | \$20 (AMEF)         |   |
| New Jersey .....          | 40    | —o—                 |   |
| New Mexico .....          | 30    | —o—                 |   |
| New York .....            | 70    | —o—                 |   |
| North Carolina .....      | 25    | \$10‡               |   |
| North Dakota .....        | 40    | —o—                 |   |
| Ohio .....                | 75    | —o—                 |   |
| Oklahoma .....            | 20    | —o—                 | Dues \$25 effective 1/1/57  |
| Oregon .....              | 42    | —o—                 |   |
| Pennsylvania .....        | 40    | —o—                 |   |
| Rhode Island .....        | 40    | —o—                 |   |
| South Carolina .....      | 50    | —o—                 |   |
| South Dakota .....        | 20    | —o—                 |   |
| Tennessee .....           | 75    | —o—                 |   |
| Texas .....               | 25    | —o—                 |   |
| Utah .....                | 50    | —o—                 |   |
| Vermont .....             | 50    | —20—                |   |
| Virginia .....            | 35    | —o—                 |   |
| Washington .....          | 25    | —o—                 |   |
| West Virginia .....       | 35    | —o—                 |   |
| Wisconsin .....           | 25    | —o—                 |   |
| Wyoming .....             | 65    | —o—                 |   |
|                           | 25    | —o—                 |   |

\*\*Voluntary assessment for building addition.

\*Baltimore City members.

†County Society members.

‡Effective 1/1/57 for employees' pension fund.

# anxiety is part of **EVERY ILLNESS**<sup>1</sup>

The physically sick patient faces two stresses—the sickness and the anxiety that it brings.<sup>1</sup> All too often, the anxiety is a threat to the patient's progress. It may intensify symptoms, give uncertainty to therapy, and impair rapport.

To combat the anxiety component of physical illness, EQUANIL promotes equanimity, relieves muscle tension, and encourages normal sleep.<sup>2</sup> By these specific actions, EQUANIL gives breadth to the treatment program—expands the physician's resources.

Supplied: Tablets, 400 mg., bottles of 50.

Usual Dose: 1 tablet, t.i.d.

1. Braceland, F.J.: Texas State J. Med. 51:287 (June) 1955.

2. Lemere, F.: Northwest Med. 54:1098 (Oct.) 1955.



**Meprobamate**

(2-methyl-2-n-propyl-1,3-propanediol dicarbamate)

Licensed under U.S. Patent No. 2,724,720

\*Trademark

**anti-anxiety factor with muscle-relaxing action**

# American Medical Association

## 109th Annual Meeting

Chicago, Illinois—June, 1956

### Civil Defense

On June 9, 1956, more than 300 physicians and national, state and local civil defense leaders attended the fourth national Medical Civil Defense Conference held Saturday in the Morrison Hotel.

The conference, sponsored by the Council on National Defense of the American Medical Association in conjunction with the AMA's 105th Annual Meeting, focused special attention on the physician's role in medical disaster preparedness on local and national levels.

Findings of a nationwide Congressional inquiry into civil defense were reported to the opening session of the conference by Rep. Chet Holifield of the 19th California district, Chairman of the House Subcommittee on Military Operations.

Allocation, distribution and utilization of the Federal Civil Defense Administration's new 200-bed emergency hospital were subjects of a panel discussion which also included a report on results of a recent field test of the hospital at Fort Meade, Maryland.

Roles of the AMA and physicians in medical disaster preparedness were outlined by Dr. Harold C. Lueth of Evanston, Ill., Chairman of the Council's Committee on Civil Defense, and Dr. R. A. Benson of Bremerton, Wash., a member of the Council.

The discussion program was augmented by exhibits, civil defense films and mannikin demonstrations of medical techniques adaptable for disaster training of civil defense volunteers.

### Conference of Presidents

The twelfth annual Conference of Presidents and Other Officers of State Medical Societies was held Sunday, June 10, 1956, in the Grand Ball Room of the Palmer House, in Chicago. This organization was founded by Andrew P. Brunck, M.D., then President of the Michigan State Medical Society. It has developed into a proud and influential group having average attendance of several hundreds, with outstanding speakers each year. The talks are printed and distributed afterwards to those who registered and attended.

Reports of officers and committees, and selection of a President-elect, John W. Green, M.D., of Vallejo, California, were followed by installation of the new President, Guthrie Y. Graves, M.D., of Bowling Green, Kentucky. President Charles L. Farrell, M.D., of Pawtucket, R. I., then made appropriate remarks and introduced the speakers.

President Graves spoke of "The Medical Practi-

tioner. Yesterday, Today, and Tomorrow." Henry Viscardi, President of Abilities, Inc., West Hampton, New York, legless and with but one arm, who never walked until he was twenty-eight, told of his company which he organized with four people, all handicapped. They have shown a profit each year and now have about 500 workers and an income of about a million and a half dollars. His talk was very inspiring. He told the Congressional Committee recently that there are no completely handicapped people.

Howard Pyle, former Governor of Arizona, now Administrative Aid to the President, spoke about "The Body Politic." Among other things, he urged medical leaders to exert most of their activities in supporting some program, and not forever be in opposition. One can become known to his great disadvantage as always "agin" a proposition, he said. The fourth speaker was Dr. Allen Stockdale, of the National Association of Manufacturers. His talk entitled "The Healer Goes Forth," gave a glimpse into the future of the practice of medicine, and what we may look for in the very near future as the result of present research soon to be used.

The meeting closed with a cocktail party.

### House of Delegates

Hospital accreditation, evaluation of graduates of foreign medical schools, private practice by medical school faculty members, federal aid to medical education and premature publicity on new drugs were among the major subjects acted upon by the House of Delegates.

Dr. David B. Allman, surgeon of Atlantic City, N. J., was named unanimously as president-elect for the coming year. A member of the AMA Board of Trustees since 1951 and also chairman of the Committee on Legislation, Dr. Allman will become president of the American Medical Association at the June, 1957, meeting in New York City. He will succeed Dr. Dwight H. Murray of Napa, California, who took office at the Tuesday evening inaugural program in the Chicago Civic Opera House.

The House of Delegates selected Dr. Walter L. Bierring of Des Moines, Iowa, as recipient of the 1956 Distinguished Service Award of the American Medical Association for his long and outstanding contributions to medicine and humanity. Dr. Bierring, a past president of the AMA, was honored for his achievements in the fields of public

(Continued on Page 906)



# MERCK SHARP & DOHME

DIVISION OF MERCK & CO., INC.

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On August 1, 1956, Sharp & Dohme, the pharmaceutical and biological division of Merck & Co., Inc., adopts the name "Merck Sharp & Dohme" and a new trademark to reflect the teamwork which has already produced significant new medical products. • Developing modern medical products and making them widely available requires teamwork of the highest order in research, production, and distribution. The desire to achieve this unity of effort prompted the merger of Merck & Co., Inc., and Sharp & Dohme, Inc., three years ago. • Merck Sharp & Dohme—combining in name as well as in fact the traditions and experience of two time-honored leaders in the medicinal field—offers bright promise for further advances in helping physicians conquer disease.



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*Pharmaceuticals • Biologicals*  
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## AMERICAN MEDICAL ASSOCIATION

(Continued from Page 904)

health and medical examining board work. He formally accepted the award at the Tuesday inaugural program.

Total registration at the end of the fourth day of the meeting, with half a day still to go, had reached 22,394, including 9,793 practicing physicians and 12,601 residents, interns, medical students and guests.

**Hospital Accreditation.**—The House of Delegates approved the report of the Committee to Review the Functions of the Joint Commission on Accreditation of Hospitals, which was appointed by the Speaker as a result of action taken at the June, 1955, meeting. The Committee came to the following conclusions:

1. Accreditation of hospitals should be continued.
2. The Joint Commission should maintain its present organizational representation.
3. The Board of Trustees should report annually to the House of Delegates on the activities of the Joint Commission.
4. Physicians should be on the administrative bodies of hospitals.
5. General practice sections in hospitals should be encouraged.
6. Staff meetings required by the Joint Commission are acceptable, but attendance requirements should be set up locally and not by the Commission.
7. The Joint Commission should not concern itself with the number of hospital staffs to which a physician may belong.
8. The Joint Commission is not and should not be punitive.
9. The Joint Commission should publicize the method of appeal to hospitals that fail to receive accreditation.
10. Reports on surveys should be sent to both administrator and chief of staff of hospital.
11. Surveyors should be directly employed and supervised by the Joint Commission.
12. Surveyors should work with both administrator and staff.
13. New surveyors should receive better indoctrination.
14. Blue Cross and other associations should be requested not to suspend full benefits to non-accredited hospitals until those so requesting have been inspected.
15. The American Medical Association should conduct an educational campaign for doctors relative to the functions and operations of the Joint Commission.
16. The Committee also suggests that the American Medical Association and the American Hospital Association encourage educational meetings for hospital boards of trustees and administrators either on state or national levels to acquaint these bodies with the functions of accreditation.
17. This Committee asks to be discharged upon submission of this report to the House of Delegates.

The House also approved a reference committee suggestion that the following statement be added to strengthen the report:

The Committee recommends that the commissioners to the Joint Commission on Accreditation of Hospitals, appointed by the Board of Trustees of the American Medical Association, urge that Commission to study:

1. The problems of the exclusion from hospitals and arbitrary limitation of the hospital privileges of the general practitioner, and

2. Methods whereby the following stated principles may be achieved:

"The privileges of each member of the medical staff shall be determined on the basis of professional qualifications and demonstrated ability."

"Personnel of each service or department shall be qualified by training and demonstrated competence, and shall be granted privileges commensurate with their individual abilities."

**Graduates of Foreign Medical Schools.**—The House of Delegates approved in principle a program for the evaluation of graduates of foreign medical schools seeking hospital positions in the United States. The proposed program was developed by the Cooperating Committee on Graduates of Foreign Medical Schools, representing the AMA Council on Medical Education and Hospitals, American Hospital Association, Association of American Medical Colleges and Federation of State Medical Boards of the United States.

The following principles were emphasized by the Council on Medical Education and Hospitals in its report recommending AMA participation in the program:

1. Although the responsibility to share educational opportunities in medicine is recognized, the primary concern must be for the health care of the American public. Thus, before assuming responsibility for the care of patients as interns or residents, all graduates of foreign medical schools (immigrants, exchange students and American graduates of foreign medical schools) should give evidence, as nearly as can be measured, of having reached a level of educational attainment comparable to that of students in American schools at the time of graduation.

2. The primary objective of this Committee is to devise an effective mechanism for measuring educational attainment in the absence of intimate and continuing knowledge of the educational background of foreign-trained physicians. This mechanism should provide hospitals with pertinent information regarding the medical qualifications of foreign-trained physicians seeking positions as interns or residents. It should not interfere with the hospital's privilege of making its own selection among qualified physicians, nor should it serve as a substitute for or interfere with the normal licensure procedures of the various state boards.

3. It is not intended that this mechanism be applicable to those foreign medical school graduates in this country as temporary students participating in programs of medical and related studies in recognized universities, medical schools and postgraduate schools, who by the very nature of their study are not involved in the responsibility of patient care.

The proposed plan calls for establishment of a central administrative organization to evaluate the medical credentials of foreign trained physicians desiring to serve as interns or residents in American hospitals. Basic requirements would include satisfactory evidence of at least 18 years of total formal education, including a minimum of 32 months in medicine exclusive of any time which

(Continued on Page 908)

# The Importance of Rescinnamine in

# Rauwiloid<sup>®</sup>

The Original Alseroxylon Fraction of India-Grown Rauwolfia Serpentina, Benth.

The isolation of rescinnamine,<sup>1</sup> another potent alkaloid in Rauwolfia serpentina, has substantiated two important points:

A—It discredits the erroneous opinion that reserpine is *the* sole active principle of Rauwolfia;<sup>2</sup>

B—It helps to define the advantages of Rauwiloid, the alseroxylon fraction of Rauwolfia serpentina, which presents desirable alkaloids<sup>3</sup> of the Rauwolfia plant (among them reserpine and rescinnamine) but is freed from undesirable alkaloids and the dross of the crude root.

Pharmacologic and clinical evaluation has shown rescinnamine to be similar to reserpine in antihypertensive activity, but to be considerably less sedative and much less apt to lead to lethargy and mental depression.<sup>4, 5</sup>

The interaction of reserpine, rescinnamine, and other contained alkaloids may well account for the balanced and desirable clinical behavior of Rauwiloid.

The dosage of Rauwiloid is simple and definite: Merely two 2 mg. tablets at bedtime. For maintenance, one tablet usually suffices.

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LOS ANGELES

## AMERICAN MEDICAL ASSOCIATION

(Continued from Page 906)

in this country would be considered as premedical study or internship. Applicants with satisfactory credentials then would take a screening examination to determine their medical knowledge and their facility with the English language. Successful applicants then would be certified to hospitals and other interested organizations, with the approval of the foreign-trained physician concerned.

**Private Practice by Medical School Faculty Members.**—Another major action by the House involved the problem of private practice by medical school faculty members, which has been under study by the Committee on Medical and Related Facilities of the Council on Medical Service. The House adopted a Council report which stated "that it shall be the policy of the American Medical Association that funds received from the private practice of medicine by salaried members of the clinical faculty of the medical school or hospital should not accrue to the general budget of the institution and that the initial disposition of fees for medical service from paying patients should be under the direct control of the doctor or doctors rendering the service."

It was further recommended that adequate liaison be developed and maintained between each county medical society and any medical school or schools in its area; that the Council on Medical Education and Hospitals and the Association of American Medical Colleges urge all medical schools to assist and work with medical societies in developing such liaison, and that publicity emanating from a medical school should be in good taste and of a type which has the approval of the general medical community in that area.

The adopted report also said:

"It is not in the public or professional interest for a third party to derive a profit from payment received for medical services, nor is it in the public or professional interest for a third party to intervene in the physician-patient relationship."

**Federal Aid to Medical Schools.**—One of the most controversial subjects of debate on the floor of the House was a resolution expressing strong opposition to S. 1323, a bill in Congress providing for one-time, matching grants to medical schools for construction purposes. The Association in recent years has been supporting such legislation in principle, with certain reservations concerning details of some provisions. The House reaffirmed that policy by approving a reference committee statement which said:

"We appreciate the intent with which this resolution was introduced, but at the same time we feel that there are many economic and geographical factors involved, which might not make this resolution practical on a

national level. Inasmuch as no evidence was offered to this Committee to justify a change in the previously declared policy of the House of Delegates, your Committee recommends that this resolution be not adopted."

**Premature Drug Publicity.**—The House adopted a substitute resolution which read:

WHEREAS, In recent years, events have indicated the necessity for a closer liaison between the pharmaceutical manufacturer and the American Medical Association; and

WHEREAS, In view of the tremendous number of new drugs being developed and the expanding research programs in medical colleges, clinics and hospitals being financed by the drug industry, it is imperative that the manufacturer and the medical profession develop co-operatively guiding principles which will protect the American people from being subjected to the premature release of information pertaining to new products or techniques; and

WHEREAS, Competition within the pharmaceutical industry has become extremely keen so that in the advertising of their products drug manufacturing firms have been forced into the expenditure of larger and larger sums of money and in increasingly broader fields of advertising; therefore be it

RESOLVED, That the Board of Trustees of the American Medical Association appoint a liaison committee to meet with representatives of the pharmaceutical manufacturers to accomplish this objective.

**Miscellaneous Actions.**—Among many other actions on a wide variety of subjects, the House also:

Approved a Board of Trustees statement on Social Security which included the following:

"It is imperative that we distinguish clearly between this problem of coverage of physicians and the far more dangerous disability proposal. The fact should be recognized that the shape of medical practice in the future is not directly related to the inclusion or exclusion of physicians under OASI. It is a matter of vital importance to us as individuals, but it cannot, per se, stimulate further government intrusion into medical care. On the other hand, the disability amendment obviously brings the Social Security Administration closer to the regulation of medical care than ever before."

Adopted a resolution amending the Bylaws to provide that the Vice President, Treasurer, Speaker and Vice Speaker of the House of Delegates shall be ex officio members of the Board of Trustees with all the rights and duties of the Board without the right to vote.

Increased membership of the Council on Medical Service from six to nine active or service members and eliminated all ex officio members except the immediate Past President.

Directed the Council on Medical Service and the Council on Industrial Health to reconsider the "Guiding Principles for Evaluating Management and Union Health Centers" through their joint Committee on Medical Care for Industrial Workers and to so revise the guides that they conform completely with the Principles of Medical Ethics.

Authorized the Committee on Federal Medical Services to make a continuing study of all aspects

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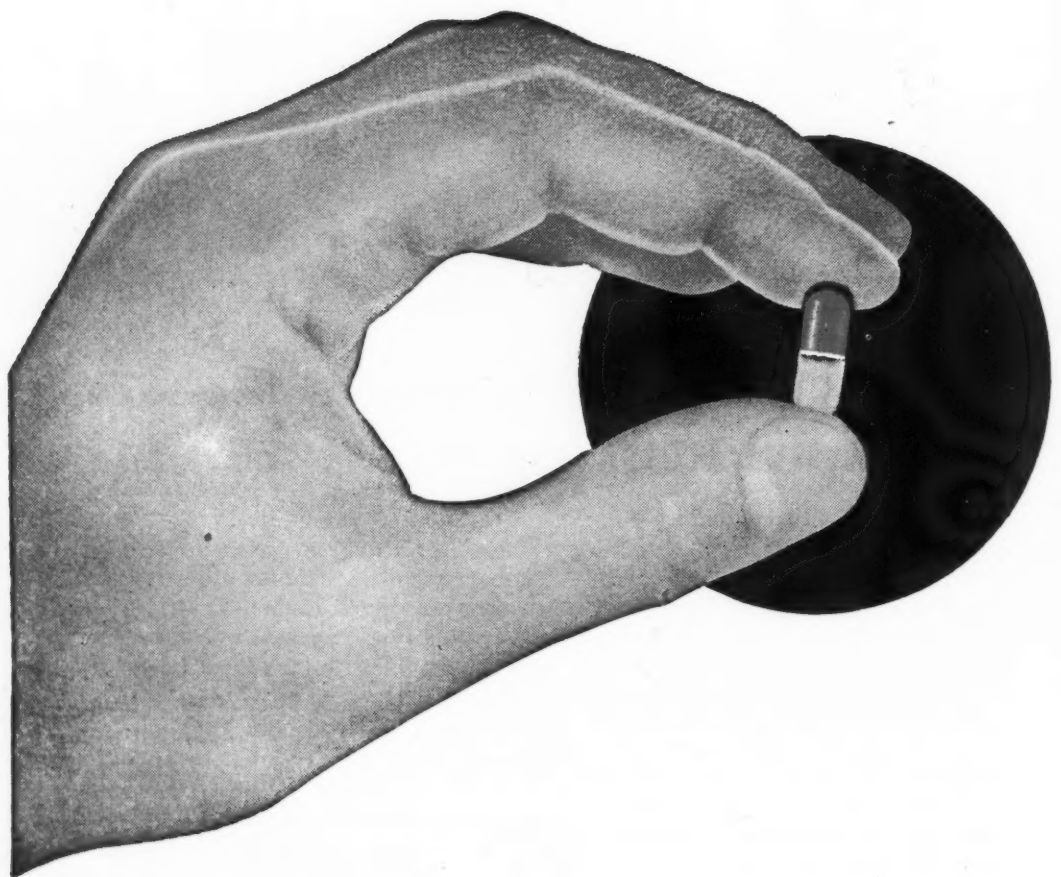
AUGUST, 1956

Say you saw it in the Journal of the Michigan State Medical Society

909

**NOW AVAILABLE....**  
**to overcome specific**  
**infections that do**  
**not respond to any**  
**other**  
**antibiotic<sup>1,2,3</sup>....**

**New...**



TODAY's resistant pathogens are the tough survivors of a dozen widely-used antibiotics. Certain organisms, notably *Staphylococcus aureus*<sup>4</sup> and susceptible strains of *Proteus vulgaris*, produce infections which have been resistant to all clinically useful antibiotics.

To augment your armamentarium against these resistant infections, 'CATHOMYCIN' (Novobiocin, Merck), derived from an organism recently discovered and isolated in the Merck Sharp & Dohme Research Laboratories,<sup>1</sup> is now available.

**SPECTRUM**—'CATHOMYCIN'<sup>1,2,3,5,6</sup> has also been shown to be active against other organisms including—*D. pneumoniae*, *N. intracellularis*, *S. pyogenes*, *S. viridans* and *H. pertussis*, but clinical evidence must be further evaluated before 'CATHOMYCIN' can be recommended for these pathogens.

**ACTION**—'CATHOMYCIN' in optimum concentration is bactericidal. Cross-resistance with other antibiotics has not been observed.<sup>7</sup>

**TOLERANCE**—'CATHOMYCIN' is generally well tolerated by most patients.<sup>5,6,8,9,10,11</sup>

# 'CATHOMYCIN'

(Crystalline Sodium Novobiocin, Merck)

**SODIUM**

**ABSORPTION**—'CATHOMYCIN' is readily absorbed,<sup>5,6,9</sup> and oral dosage produces significant blood and tissue levels which persist for at least 12 hours.<sup>7</sup>

**INDICATIONS:** Clinically 'CATHOMYCIN' has proved effective for cellulitis, carbuncles, skin abscesses, wounds, felons, paronychia, varicose ulcer, pyogenic dermatoses, septicemia, bacteremia, pneumonia and enteritis due to *Staphylococcus* and infections caused by susceptible strains of *Proteus vulgaris*.<sup>6,7,8,9,10,11,12,13,14</sup> Also, it is of particular value as an adjunct in surgery since staphylococcal infections seem prone to complicate postoperative courses.

**DOSAGE:** Four capsules (one gram) initially and then two capsules (500 mg.) twice daily.

**SUPPLIED:** 'CATHOMYCIN' Sodium (Crystalline Sodium Novobiocin, Merck) in capsules of 250 mg., bottles of 16. 'CATHOMYCIN' is a trademark of Merck & Co., Inc.

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of VA medical activities under the basic policy established in June, 1953, and suggested reconsideration of the temporary exceptions made at that time with respect to neuropsychiatric and tuberculous disorders.

Recommended that the Board of Trustees select New York City as the place of the 1961 annual meeting.

**Opening Session.**—At the Monday opening session Dr. Elmer Hess, outgoing AMA President warned that the medical profession must be prepared to face an all-out drive by some labor groups for national compulsory health insurance. Dr. Dwight H. Murray, then President-Elect, told the House that general practitioners and specialists must guard against "any cleavage within our profession," and he urged strength through unity.

Dr. Lowell T. Coggeshall, special assistant to Secretary Marion B. Folsom of the U. S. Department of Health, Education and Welfare, assured the House that the over-all medical objectives of HEW are in accord with those of the AMA. A memorial plaque honoring the late Dr. Carl M. Peterson, secretary for seventeen years of the AMA Council on Industrial Health, was presented by Admiral Ross T. McIntire on behalf of the President's Committee on Employment of the Physically Handicapped. The Illinois State Medical Society presented a check for \$164,940 to the American Medical Education Foundation.

**Inaugural Program.**—Dr. Murray, in his inaugural address at the Tuesday evening ceremony in the Chicago Civic Opera House, declared that "what we need most in medicine today is to find some way of combining modern scientific methods with the personal, friendly touch of the old-time family doctor." The inaugural program, which included the Bluejacket Choir of the U. S. Naval Training Center at Great Lakes, Ill., was telecast over Station WBKB in Chicago.

**Election of Officers.**—In addition to Dr. Allman, the new President-Elect, the following officers were elected:

Dr. F. S. Crockett of Lafayette, Indiana, Vice President; Dr. George F. Lull of Chicago, Secretary; Dr. J. J. Moore of Chicago, Treasurer; Dr. E. Vincent Askey of Los Angeles, Speaker, and Dr. Louis Orr of Orlando, Florida, Vice Speaker.

Dr. Julian Price of Florence, South Carolina, was reelected to the Board of Trustees, and Dr. Hugh Hussey of Washington, D. C., was named to succeed Dr. Allman. Dr. Robertson Ward of San Francisco was elected to the Judicial Council to succeed Dr. Walter F. Donaldson.

Reelected to the Council on Medical Education and Hospitals were Dr. Guy A. Caldwell of New

Orleans and Dr. John W. Cline of San Francisco. Dr. Walter E. Vest of Huntington, West Virginia, was named to succeed Dr. Louis A. Buie on the Council on Constitution and Bylaws.

Elected to the Council on Medical Service were Dr. Carlton Wertz of Buffalo, New York, to succeed himself, and Dr. J. F. Burton of Oklahoma City to succeed the late Dr. A. C. Scott, Jr., of Texas. Named for the three new places created on the Council on Medical Service were Dr. Thomas Danaher of Torrington, Connecticut; Dr. R. M. McKeown of Coos Bay, Oregon, and Dr. Lafe Ludwig of Los Angeles.

### Other Matters of Importance

Many important developments of a national medical convention never appear as resolutions of the House of Delegates. Dr. Elmer Hess, retiring President, called special attention to the continuing policy of labor union leaders who took every opportunity to promote the compulsory medical and health insurance administered by the federal government at no cost to the consumer. This pops up on every side.

The incoming President, Dr. Dwight H. Murray, emphasized the personal friendly touch of the old-time practitioner. He said:

"Our mutual task—both physicians and the public is to regain our individuality. To do so, we must humanize and personalize the practice of modern medicine."

He made several suggestions to physicians and patients for getting back to the "human side of medicine."

To doctors, he suggested that they give more time and personal interest to each patient and that they be frank about illness and conditions. Above all, he said, doctors should be "friendly, patient and sympathetic."

To the public, he said:

"No doctor is a miracle man. All the advancements of science can't make a sick man well unless he tries to co-operate with his physician."

"So choose your doctor carefully, have faith in his ability, follow his instructions, and give him a fair chance to show he can help you."

Dr. Murray also said that "modern medical care must be looked upon as a matter of teamwork."

"Modern medical care is a complex service requiring the coordinated efforts of family doctors, all kinds of specialists, chemists, pharmacists, researchers, laboratory and x-ray technicians, nurses, dieticians, and many other groups of auxiliary personnel. All must rightly be considered a part of the medical care teams."

Noting that there is a new interest in the role of the general practitioner, Dr. Murray said many medical schools are "revising their curricula so that they can give their students better-rounded,

(Continued on Page 914)

DOCTORS EVERYWHERE NOW KNOW WHY

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Professional men who have studied the microscopic analysis of the Viceroy filter now know why the Viceroy taste is smoother—never rough. Only Viceroy has 20,000 tiny filters in every tip—twice as

many filters as the other two largest-selling filter brands. That is why Viceroy's are smoother by far—never, never rough. That is why so many doctors now smoke and recommend Viceroy's.

Yes, smoother taste because there are  
**TWICE AS MANY FILTERS  
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Viceroy's exclusive filter is made from pure cellulose—soft, snow-white, natural!



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better-coordinated preparation for the practice of medicine."

More and more hospitals, he said, also are establishing residency training programs in the field of general practice. He also reminded his audience that the AMA House of Delegates has "urged all community or general hospitals to give proper staff recognition to competent general practitioners in keeping with their merits and demonstrated ability."

Two resolutions were presented reopening the question of contracts with optometrists, which might have continued the very active fight of last year, but the Reference Committee settled the matter in committee. The fight of a year ago is still won. Several resolutions attempted to reopen the question of osteopathy but House members were not disposed to enter the discussion at this time. Many questions await solution, and may come up again in November.

#### Scientific Sessions

Our Michigan members, besides being interested in the economic and legislative part of the program, took an active part in the scientific accomplishments. The following served as officers of Sections (all are M.D.'s unless otherwise designated): Clarence S. Linwood, Detroit, Secretary Section on Dermatology; Albert D. Ruedemann, Sr., Detroit, Chairman Section on Ophthalmology; Traian Leucutia, Detroit, Secretary Section on Radiology; Grover C. Penberthy, Detroit, Delegate Section on Surgery, General and Abdominal; Wyman C. Cole, Detroit, Secretary Section on Pediatrics.

Presenting papers or opening discussions were: E. Richard Harrell, Jr., Ann Arbor, Discussion on "Dermatomyositis and Incidence of Associated Malignancy"; John C. Rukavina, Walter E. Block and Arthur C. Curtis, Ann Arbor, "Primary Systemic Amyloidosis"; Hermann K. B. Pinkus, Monroe, Discussion on "Warty Dyskeratomas Resembling Darier's Disease"; Gordon B. Myers, Detroit, Panel Discussion on "Practical Electrocardiography in Surgery in Coarctation of the Aorta" and Panel Discussion on "Lesions of Upper Alimentary Canal Producing Chest Symptoms"; William M. Tuttle, Detroit, Panel on "Heart and Great Vessel Anomalies" with Conrad Lam, Detroit, as moderator; John F. Holt, Ann Arbor, "Pathogenesis of Macrocytic Anemias"; Frank M. Bethell, Ann Arbor, Discussion on "Anomalous Forms of Hemoglobin, Genetic Point of View" with John V. Neel, Ann Arbor, and Wolf W. Zuelzar, Detroit, Discussion.

Additional contributions from Michigan were: "Diagnosis of Schistomiasis Mansoni" with Robert T. Lyons, Pontiac, with discussion. "New Instrument for Removing Postnatal Pack," Bernard

Weston, Detroit; "Occupational Deafness," Bruce Proctor, Detroit; "Carcinoma of the Nose and Paranasal Sinuses," Harold F. Schuknecht, Detroit, with discussion; "Cause of Death from Ruptured Intracranial Aneurysms," Robert D. Currier, Jose Bebin and Russel N. DeJong, Ann Arbor; "Intraspinal Tumors as Cause of the Pain and Disability," Edgar A. Kahn, Ann Arbor, Discussion; "Carotid Compression in Neck, Significance in Carotid Ligation," E. S. Gurdjian, J. E. Webster, and Francis A. Martin, Detroit; "Foveal Coordination, the Major Factor in Visual Learning" A. D. Ruedemann, Sr., Detroit; "Reactions of the Elements of Retina and Optic Nerve in Common Morbidities of the Human Eye" J. Reimer Wolter, Ann Arbor; "Horizontal Movements of the Eye" Mathew Alpern, Ann Arbor; "Metatarsus Primus in Varus and Mallux Valgus" Donald C. Durman, Saginaw, with Discussion by Joseph Flemming, Detroit; "Beta-Prelactone in the Preparation and Sterilization of Vaccines, Tissue Grafts and Plasma" Frank W. Hartman and Gerald A. LeGruppe, Detroit; "Plasmacytosis and Cryoglobulinemia," Milton J. Steinhardt, Detroit, Discussion; "Use of Radioactive Isotopes in the Evaluation of Gastrointestinal Function" with discussion by Harold E. Fulton, Detroit; "Hazards of Use of Sympathomimetic Drugs in Ophthalmology" John W. Henderson, Ann Arbor; "Vertical Muscle Imbalance and Scoliosis," A. D. Ruedemann, Jr., Detroit; "Selective Segmental Bronchography," with discussion by Lawrence Reynolds; "Inguinal Hernia Repair—Personal Results," Lawrence S. Falls, Detroit, with discussion; "Progress in Surgical Management of Aortic Aneurism," Conrad R. Lam, Detroit, with discussion; "Disappearance of 'Stohe' Shadows in Postoperative Cholangiograms"—Collaborators: Charles G. Johnston, Detroit, and Henry K. Ransom, Ann Arbor; "Repair of Intracardiac Septal Defect," Conrad R. Lam, Detroit; "Repair of Femoral and Inguinal Hernias," Lawrence S. Falls, Detroit.

The following had scientific exhibits: Curtis M. Hanson, Kalamazoo; J. E. Jamison, Dearborn; Clair L. Straith, Richard E. Straith, Joseph D. Carlisle, Burns G. Newby, Detroit; Edward L. Quinn, Frank Cox, Jr., James M. Colville, and Joseph Truant, Detroit; John T. Ferguson and W. H. Funderburke, Traverse City; C. Paul Hodgkinson, Paul W. Pifer, Melvin A. Block, and Donald G. Remp, Detroit; Irving M. Blatt, Philip Rubin, James M. Maxwell, John F. Holt, and John E. Magielski, Ann Arbor; Osborne A. Brines, Detroit; Carl A. Gagliardi and Margaret Stewart-Gagliardi, Detroit; Lee S. Figiel, Steven J. Figiel, and Fred K. Wietersen, Detroit; Lawrence Reynolds, William M. Tuttle, Harold E. Fulton and George F. Boone, Detroit; Joseph L. Pesch, Robert D. Larsen, Kenneth G. Bartells, and William O. Minturn, Detroit; Virgil N. Slee, Hastings, and Robert G. Hoffmann, Ann Arbor.

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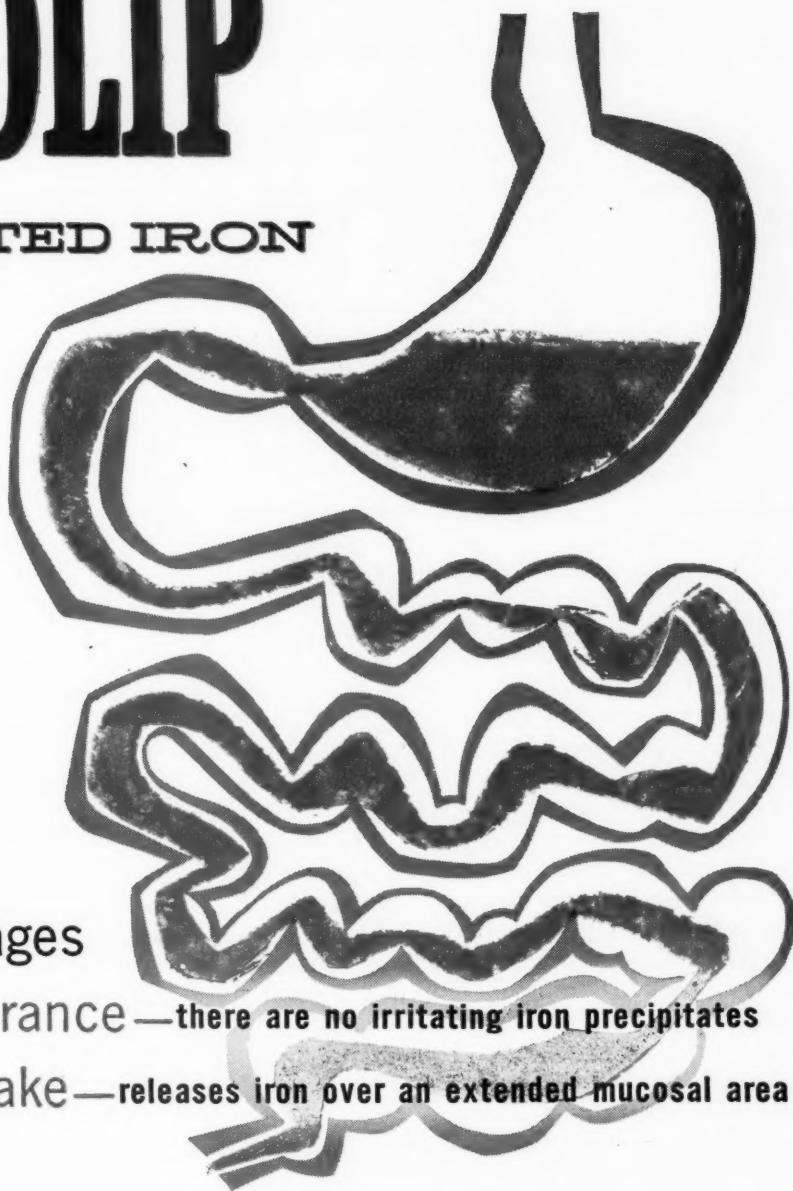
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clinical advantages

Better Iron Tolerance—there are no irritating iron precipitates

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tablets Three FERROLIP\* Tablets supply 120 mg. of iron and 360 mg. of choline base.

Dosage for Adults: 1 or 2 tablets t.i.d., for Children, 2-6 years, 1 tablet t.i.d.

syrup Six teaspoonfuls of FERROLIP Syrup supply 120 mg. of iron and 360 mg. of choline base.

Dosage for Adults. 2 to 4 teaspoonfuls t.i.d.; for Children, 2-6 years, 1 or 2 teaspoonfuls t.i.d.

drops Each cc. of FERROLIP Drops provides 16 mg. of iron and 48 mg. of choline base. The M.D.R. for infants is 0.5 cc.

supplied Tablets: Bottles of 100 and 1000; Syrup: Pints and gallons; Drops: 30-cc. dropper bottles.

**Flint,** EATON & COMPANY  
Decatur, Illinois

\*U. S. Pat. 2,575,611

# AMA Washington Letter

## THE MONTH IN WASHINGTON

If medical research doesn't move ahead in the current fiscal year (ending June 30, 1957), it won't be the fault of Congress. The seven research organizations that make up the National Institutes of Health have far more money than they have ever had, and probably much more than their directors even dared hope for last winter at the start of hearings on their budgets. Every one of the research institutes received a substantial increase over last year, and the funds of five of them were almost doubled.

The Institutes have a total of \$170.4 million to spend before next July 1. This is about 80 per cent more than they had last year. In discussing the appropriations bill on the Senate floor, Senator Lister Hill (D., Ala.) said the bulk of the money will go for grants to non-federal institutions—hospitals, medical schools, clinics and state and local organizations engaged in research.

A breakdown by disease categories shows the following picture:

For cancer research, \$48.4 million, in contrast to \$24.8 million for the previous year. This year's total is \$16 million more than the administration asked when budget requests were sent to Congress in January.

For mental health work, \$35.1 million, in contrast to last year's \$18 million. This is \$13.4 million more than had been requested originally.

For heart disease research, \$33.3 million, compared with \$18.7 million last year and \$22.1 million originally requested.

For work on arthritis and metabolic diseases, \$15.8 million, or \$5.1 million more than last year and \$2.5 million more than Congress was asked for.

For research in neurology and blindness, \$18.6 million, compared with \$9.8 million last year and \$12.1 million originally requested.

For work on allergies and infectious diseases, \$13.2 million, compared with \$7.5 million last year and \$9.7 requested.

For dental research, \$6. million. While this is small compared with money voted for other U. S. research institutes, it is almost triple the \$2.1 million spent last year. The huge increase is the result of a sustained campaign by the American Dental Association.

Senator Hill and Rep. John E. Fogarty (D., R. I.) led the fight in Congress for the record-breaking research appropriations. Under the latter's chairmanship, a House appropriations subcommittee boosted the total for the seven insti-

tutes to about \$124 million, a figure that was accepted both by the full Appropriations Committee and the House.

In addition to heading the Senate appropriations subcommittee that handled this funds bill, Senator Hill also is chairman of the Labor and Welfare Committee and extremely active in health legislation. His subcommittee pulled up the totals to the \$170 million. After the Senate-House conference committee disagreed on the spending, Rep. Fogarty carried the fight to the floor, where he persuaded the House to accept all of the higher Senate figures.

Other federal health programs, mainly concerned with disease control and hospital construction, also fared well with the Congress. The Hill-Burton program, for construction grants to hospitals, has \$125 million for the current year, or \$14 million more than last year. For vocational rehabilitation grants, the figure is \$41.5 million, a \$2.7 million increase; for general public health assistance to states, it is \$18.16 million, a \$600,000 increase; for Indian health work, it is \$38 million, a \$3.3 million increase.

NOTES: With Salk vaccine being released in every expanding volume, the Public Health Service is urging states and communities to increase the priority age to twenty and to use up supplies as fast as received. Said Secretary Folsom: "I urge parents, physicians, and health officials to cooperate in making the maximum use of the increasing supply as soon as it becomes available. . . ."

Civil Aeronautics Administration, believing the time has come to review procedures in pilot medical examinations, has hired a private organization to conduct a thorough investigation and make recommendations. Two questions: Should lower standards be allowed for older, experienced pilots? Should crew members and ground crewmen, as well as pilots, be examined periodically?

Less than three months after his third appointment to a four-year term as Surgeon General of U. S. Public Health Service, Dr. Leonard Scheele resigned to take a post in the pharmaceutical industry so he could "provide more properly" for his family.

Although no new legislation was enacted in that field, witnesses at a long series of hearings on civil defense were pretty much in agreement that the job can't be done properly unless more authority is voted to the Federal Civil Defense Organization.



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peach-colored, newest  
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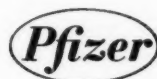
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broad-spectrum therapy

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PFIZER LABORATORIES, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.



\*†Brand of oxytetracycline

AUGUST, 1956

*Say you saw it in the Journal of the Michigan State Medical Society*

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# Cancer Comment

## PUBLIC WARNING AGAINST HOXSEY CANCER TREATMENT

Following is a release issued April 4 by the Food and Drug Administration, U. S. Department of Health, Education, and Welfare, Washington, D. C.

Sufferers from cancer, their families, physicians, and all concerned with the care of cancer patients are hereby advised and warned that the so-called Hoxsey treatment for internal cancer has been found by the United States Court of Appeals for the Fifth Circuit, on the basis of evidence presented by the Food and Drug Administration, to be a worthless treatment. (The court decisions can be found in Volume 198, Federal Reporter, Second Series, page 273, and Volume 207, Federal Reporter, Second Series, page 567.)

The Federal Food, Drug, and Cosmetic Act authorizes dissemination of information regarding drugs in situations involving imminent danger to health or gross deception of the consumer. (21 U.S.C. 375 (b) This authority has been delegated to the Commissioner of Food and Drugs by the Secretary of Health, Education, and Welfare, 20 Federal Register 1998.)

The Hoxsey treatment for internal cancer involves such drugs. Its sale represents a gross deception to the consumer. It is imminently dangerous to rely upon it in neglect of competent and rational treatment.

The Hoxsey treatment costs the patient \$400 plus \$60 in additional fees; expenditures which will yield nothing of any value in the care of cancer. It begins with a superficial and inadequate examination of the patient at the Hoxsey Cancer Clinic, Dallas, Texas, or Portage, Pennsylvania. The patient at Dallas is then supplied with one of the following "cancer" medicines: Black pills, red pills, a brownish-black liquid, or a light red liquid. The black pills and the brownish-black liquid contain: Potassium iodide, licorice, red clover blossoms, burdock root, Stillingia root, berberis root, poke root, cascara sagrada, prickly ash bark, and buckthorn powder. The red pills contain potassium iodide, red clover, Stillingia root, poke root, buckthorn, and pepsin. At Portage the patient is given the same "cancer" medication although the colors of the pills are different. The light red liquid medicine is potassium iodide in elixir of lactated pepsin. There is evidence that potassium iodide accelerates the growth of some cancers.

The Food and Drug Administration has conducted a thorough and long-continuing investigation of Hoxsey's treatment. His claimed cures have been extensively studied and the Food and Drug Administration has not found a single verified cure of internal cancer effected by the Hoxsey treatment. In addition, the National Cancer Institute of the United States Public Health Service has reviewed case histories submitted by Hoxsey and advised him that the cases provided no scientific evidence that the Hoxsey treatment has any value in the treatment of internal cancer.

On October 26, 1953, Harry M. Hoxsey, the Clinic, and all persons in active concert with him were enjoined by the United States District Court at Dallas, Texas, from shipping their worthless cancer medicines in interstate commerce with labeling representing, suggesting, or implying that the products are effective in the treatment of any type of internal cancer. While the Government intends to prosecute violations of the injunction, this warning is necessary for the immediate protection of cancer victims who may be planning to take the Hoxsey treatment.

Those afflicted with cancer are warned not to be misled by the false promise that the Hoxsey cancer treatment will cure or alleviate their condition. Cancer can be cured only through surgery or radiation. Death from cancer is inevitable when cancer patients fail to obtain proper medical treatment because of the lure of a painless cure "without the use of surgery, x-ray, or radium" as claimed by Hoxsey.—*Journal A.M.A.* (April 21, 1956, P. 1423) reprinted at the request of the Cancer Coordinating Committee.

From experimental work on skin cancer the active etiological component is ultraviolet radiations of the wave length of about 2,967 Angstrom units.

Using the existing facts about etiology, a considerable degree of control of skin cancer in populations can be achieved by prevention.

Today, probably no country in the world has an accurate knowledge of its cancer incidence rate.

Cancer incidence can be estimated with reasonable closeness from the number of reported cases and the number of undiagnosed cases revealed by autopsies on samples of the population.

The cancer mortality rate represents the size of the problem in education and research facing a country.

If every type of cancer is found everywhere and in all peoples, then the causes for these cancers must be ubiquitous.

Not only does man get lung cancer in every part of the world but his domestic animals and the wild animals about him do also.

The largest and most important problem today on the etiology of cancer is still the relative importance of extrinsic and intrinsic factors.

It has been realized in recent years that a racial factor in a cancer, even though shown to be hereditary, does not necessarily mean that it is genetical.

Recently, the National Cancer Institute estimated that the number of new cancer cases (all sites) increased 34 per cent during the ten-year period 1937 to 1947 and of this, only 7 per cent could be accounted for by the increase in life span of the population.

There is no indication that one type of benign breast disease is any more precancerous than another. Thus, it is a salutary safeguard to suggest that all patients with benign breast disease be regularly examined at periodic intervals.

The diagnosis of cancer of the larynx hinges on one word: hoarseness.

Any hoarseness persisting over two weeks, particularly in people past thirty-five to forty years of age, is cancer until proved otherwise.

**NOW AVAILABLE...**

**a unique new antibiotic  
of major importance**

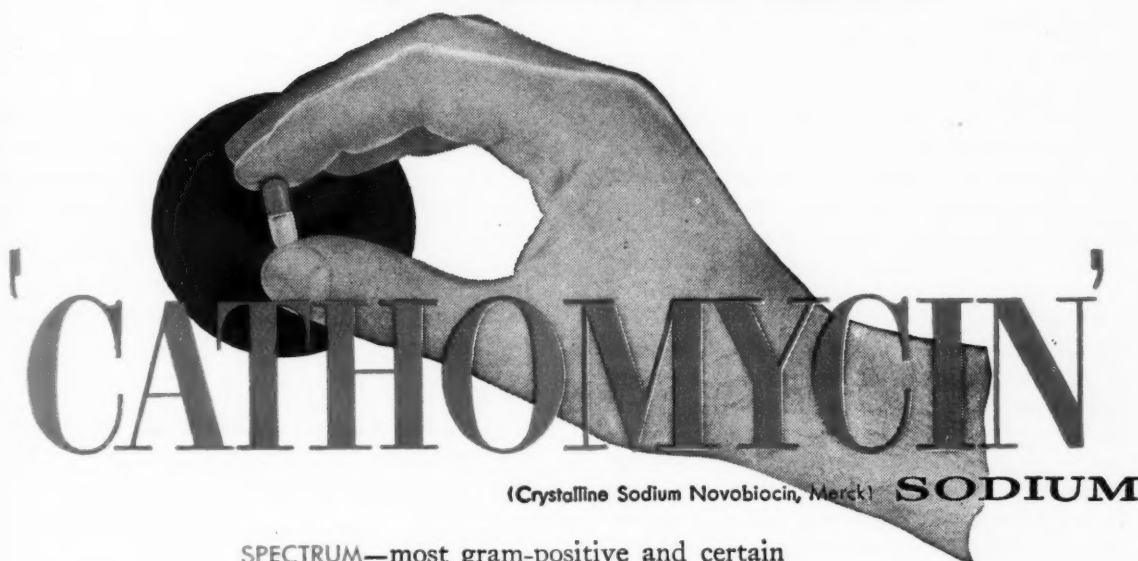
**PROVED EFFECTIVE AGAINST**

**SPECIFIC ORGANISMS**

*(staphylococci and proteus)*

**RESISTANT TO ALL OTHER**

**ANTIMICROBIAL AGENTS**



**SPECTRUM**—most gram-positive and certain gram-negative pathogens.

**ACTION**—bactericidal in optimum concentration even to resistant strains.

**TOXICITY**—generally well tolerated. This is more fully discussed in the package insert.

**ABSORPTION**—oral administration produces high and easily-maintained blood levels.

**INDICATIONS**—cellulitis, pyogenic dermatoses, septicemia, bacteremia, pneumonia and enteritis due to *Staphylococcus* and infections involving certain strains of *Proteus vulgaris*, including strains resistant to all other antibiotics.

**DOSAGE**—four capsules (one gram) initially and then two capsules (500 mg.) twice daily.

**SUPPLIED**—250 mg. capsules of 'CATHOMYCIN', bottles of 16.

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# Michigan Blue Cross-Blue Shield

## Annual Non-Group Enrollment

Michigan Blue Cross-Blue Shield will hold its sixth annual statewide non-group enrollment campaign this year during the two-week period running from September 10 through September 22, 1956.

As you know, it is through this special Non-Group program that Blue Cross-Blue Shield is able to extend broad hospital and surgical coverage on a direct enrollment basis to the thousands of Michigan families who are not able to enroll through regular employee, farm or professional groups.

More than 175,000 persons have already enrolled under the Non-Group program in the five years it has been offered on a statewide basis.

Naturally, it is not possible to offer all the benefits of group coverage in a direct enrollment plan. However, because the enrollment period is limited to a two-week period and is offered on a statewide basis, the Blue Cross-Blue Shield Non-Group program is able to offer a good many of the broad benefits of group coverage even on an individual enrollment basis.

During this year's enrollment period of September 10 to 22, the non-group coverage will be open to all Michigan residents under sixty-five. Only condition is that married persons must enroll spouse and unmarried children under nineteen. The spouse can be over sixty-five.

The Blue Cross-Blue Shield non-group plan offers far and away the best coverage available at the price on an individual enrollment basis.

For example, maximum daily room allowance is now \$12 a day. All other contract services are provided without limit. Maternity benefits, subject of course to the usual nine month waiting period, are exactly the same as for any other admission, plus routine nursery care for the newborn.

The Non-Group program provides thirty days of hospital care for each family member covered, with another thirty days available each time the member has been discharged from a hospital at least six months.

This year's enrollment campaign will get wide publicity and will be backed with advertising, of course.

But Dr. Wilfrid Haughey, president of Michigan Medical Service (Blue Shield), emphasized that the key to success of the campaign—as it has been in the past—lies in the hands of Michigan's doctors themselves.

"In all five previous enrollment campaigns, the statistics show the physicians played a major role," Dr. Haughey said.

He pointed out that the great majority who have enrolled obtained their information and application from their doctor's office or from their

local hospital. And in areas where doctors were most active in backing the drive, enrollment was markedly higher.

"In short, success of the Blue Cross-Blue Shield Non-Group program really hinges on the interest and cooperation of the physicians—that is why I have stressed the key role all Michigan doctors again will play in this year's enrollment campaign," Dr. Haughey said.

By now, all doctors should have received a kit that includes a desk container and an initial supply of Non-Group enrollment folders which have a built-in application card. Also enclosed is a handy order card for an additional supply of folders.

Although the campaign is officially limited to September 10 through September 22, the counter containers and folders may be displayed and distributed to patients as soon as they are received.

However, those who wish to join *must* have the completed application in the mail by September 22, closing date of the campaign, to qualify for coverage.

The presence of even a low degree of cornification in the vaginal smear of postmenopausal cancer patients is indicative of continued estrogenic activity, either from the ovary, the adrenal, or both.

\* \* \*

Carcinoma *in situ* means cancer in its normal or original location. The lesion has been defined as "a condition in which malignant epithelial cells and their progeny are found in or near positions occupied by their ancestors before the ancestors underwent malignant transformation."

\* \* \*

A higher titer of estronase has been found in the blood of postmenopausal patients with breast cancer than in normal menopausal women.

\* \* \*

Bilateral orchiectomy inhibits the growth of primary inoperable breast cancer, especially bone metastases, in male patients.

In Lansing  
**HOTEL OLDS**  
Fireproof  
400 ROOMS

# The JOURNAL

of the Michigan State Medical Society

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOLUME 55

AUGUST, 1956

NUMBER 8

## Responsibility to the Injured

By George J. Curry, M.D.  
Flint, Michigan

THERE are ten million persons injured yearly and one hundred thousand killed. Trauma is the commonest cause of death in children up to the age of thirteen. Between one and two million fractures occur each year. The home, automobile and industry furnish the major source. These factors challenge the medical profession. What are we doing about it?

### Transportation

Proper immediate care of the injured person often decides the fate, and is an important part of subsequent definitive management. It is hard to separate one from the other. Transportation thus becomes a major problem.

Cranio-cerebral, spine fractures, thoracic, abdominal and motor skeletal injuries make up the list for the most part. Any injury, irrespective of location, should be assessed immediately and handled expeditiously.

The cranio-cerebral injury should be transported gently with the patient supine or prone and the head cushioned. The fractured cervical spine should be transported the same way with the support under the neck. The fractured lumbar spine is transported face downwards. The supine position is acceptable with a support under the back. Beware of jack-knifing! The thoracic injury should

be transported in a modified Fowler's position. The fractured lower extremity should be splinted either with a traction splint or with adequate protection by any available rigid material. The upper arm may be bandaged to the lower thoracic wall and the forearm placed in a sling. Suspected fractures of the forearm may be splinted with boards, newspapers or magazines and placed in a sling.

Immediate care and subsequent transportation is handled by ambulance attendants in the large majority of cases. In many localities, morticians control the private ambulance service. It would seem logical that each ambulance attendant should *qualify* for this important responsibility. It is recommended that an educational program be projected in every community and that ambulance attendants be certified as to their proficiency. This program can be further broadened to include police, firemen, and anyone charged with responsibility for the immediate care of the injured person.

On July 21, 1941, Ordinance No. 435 was adopted by the City of Flint, Michigan. On October 17, 1949, Ordinance No. 886 was adopted to amend Ordinance No. 435.

### Ordinance No. 886

An Ordinance to amend Ordinance No. 435, entitled "An Ordinance governing the qualifications of ambulance attendants; regulating equipment to be used in first aid treatment by such attendants, and providing penalties for the violation thereof," approved July 21, 1941.

### THE CITY OF FLINT ORDAINS:

Section 1. Ordinance No. 435, entitled "An Ordinance governing the qualifications of ambulance attendants; regulating equipment to be used in first aid

Presented at the Michigan Clinical Institute, Detroit, Michigan, March, 1956.

Dr. Curry is Chief, Section for Surgery of Trauma, and Chairman, Committee on Graduate Surgical Education, Hurley Hospital, Flint, Michigan.

He is a member of the Board of Governors, as well as Chairman, Subcommittee for Transportation of the Injured, and Subcommittee on Regional Committees, Committee on Trauma, American College of Surgeons.

AUGUST, 1956

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## RESPONSIBILITY TO THE INJURED—CURRY

treatment by such attendants, and providing penalties for the violation thereof," is hereby amended by the addition of a new section to read as follows:

Section 2 (a). Certificates of fitness as ambulance attendants as provided for herein shall be renewed annually by persons holding said certificates. Renewal certificates shall be issued by the Health Officer as provided in Section 2 hereof for issuance of original certificates. Upon failure of any persons to renew said certificate as herein provided, such certificate shall be canceled by the Health Officer.

Section 2. Any certificate of fitness as ambulance attendant, issued prior to the effective date of this ordinance, shall within thirty days after the effective date of this ordinance, be renewed as provided above; provided, that any certificate issued within one year prior to the effective date of this ordinance shall be renewed annually on or before the date of the original issuance.

Section 3. Penalties for the violation of this ordinance shall be the same as provided in Ordinance No. 435 of which this is amendatory.

Approved this 3rd day of October, 1949.

Mayor

Clerk

In December, 1949, the Flint Committee on Trauma, American College of Surgeons, sponsored an educational program directed toward improvement of standards for transportation of the injured. Arrangements were made with all local ambulance attendants, police, firemen, Red Cross representatives, safety directors, et cetera, to attend a series of specially arranged lectures and demonstrations, covering the common types of injuries brought to the emergency receiving department. X-ray and anatomic specimens were demonstrated representing the different types of injuries transported. Ideal methods of handling these injuries were informally discussed. This intensified program was continued for one week and there was full attendance at each session.

The responsibility for this activity was later assumed by the Red Cross in specially arranged programs for ambulance attendants under the direct supervision of a selected instructor. The following subjects were selected: injuries of the extremities, spine and pelvis; drowning and asphyxia; burns; thoracic trauma; abdominal and cranio-cerebral trauma.

At the conclusion of this training, cards bearing the signatures of the City Health Director, Chairman of the Local Regional Committee on Trauma, A.C.S. and Chairman of the Committee on Transportation of the Injured, were presented to each one completing this course of instruction. These cards, which are certificates of proficiency, expire each year.

The City of Flint has been zoned by the police department and ambulances are directed by special instruction from police headquarters.

There is a chart in the Emergency Receiving Department at Hurley Hospital which contains the name, age, date, diagnosis, manner of transportation, name of ambulance and names of ambulance attendants. This is a permanent and continuous record of activities in each case and a means by which knowledge of good or bad transportation of the injured is obtained. Infractions are referred to the City Health Commissioner, who in turn notifies the ambulance owner and attendants. If three infractions are made, the ambulance attendant is suspended and forced to requalify. This has occurred only a few times.

All ambulances in Flint are inspected by the Red Cross ambulance attendants' instructor twice yearly for proper equipment and the information is recorded.

Flint ambulances are owned by morticians who have co-operated completely.

In December, all ambulance attendants, members of the police and fire departments, state police Red Cross instructors, safety engineers, et cetera, meet in the auditorium at Hurley Hospital. A selected program is presented on common injuries by members of the trauma and resident staffs. Actual case reports with x-ray films are shown so these men have a knowledge of the cases that they might have transported. A question and answer period follows. Special commendation is given to those ambulances and their attendants by name who have established an excellent record. Those who have an inferior record are not eliminated in the discussion. It is at this time that a roster of all the attendants is taken relative to the obtaining of the certification cards for the ensuing year beginning January 1. Appropriate stickers have been designed and presented to those ambulances having good records. These stickers contain the names of the Flint Committee on Trauma and American College of Surgeons.

Among other cities in the United States which have similar ordinances are San Francisco, Butte, Minneapolis, Syracuse and Kansas City, Missouri. Other cities in Michigan are in the process of obtaining ordinances or have established educational programs for groups who handle the injured person. During the past six years there have been many communications from different parts of the United States seeking information concerning the Flint Plan. In some areas efforts are being di-

## RESPONSIBILITY TO THE INJURED—CURRY

rected toward making it a mandatory state requirement.

The value of this program was shown conclusively during the Flint Tornado, June, 1953, when nine hundred people were injured within a few minutes and one hundred sixteen were killed. This story, in detail, was published in the *American Journal of Surgery* and the *Bulletin of the American College of Surgeons*, last year.

There has been gradual improvement in the quality of transportation to the hospital. It has been gratifying to observe the interest shown by each ambulance attendant, particularly when he is made to understand that he is part of the whole story in the care of the injured person. During a six-year period, 27,000 ambulance-transported cases were brought to Hurley Hospital receiving room and subsequently admitted. There were seventy infractions considered too bad for transportation. Each year showed a decreasing number.

### The Ambulance Attendant

The ambulance attendant participates significantly in the management of an injured person. Since he is responsible for immediate care and transportation to the hospital, his position demands certain qualifications. These should be evaluated on the basis of character, knowledge, personality, health, interest and dependability.

A special educational program must be arranged for his training. This may be done in several ways. Integration of Red Cross facilities under a special instructor has been successful in Flint, Michigan and other United States localities. Instruction may be given by an organized group from hospital house staffs, or under county medical society sponsorship. There are many areas in the United States where committees on trauma exist. These groups are part of the organized postgraduate educational program of the American College of Surgeons and have increased in number and scope during the past thirty-four years. One of their major objectives has been to encourage and standardize more efficient immediate care and transportation of the injured. Since 1949 there has been impressive expansion and improvement. Such committees have organized specific instructional courses for the ambulance attendant.

Since 1941, the Flint Committee on Trauma, A.C.S., and the Section for the Surgery of Trau-

ma, Hurley Hospital, have been especially interested in transportation of the injured.

At Hurley Hospital, during the past six years there has been marked improvement in immediate care and transportation of the injured to the hospital. Each attendant is examined yearly, required to carry a card indicating his qualifications and obliged to take the special course of instruction arranged through the Red Cross curriculum. Ambulances are inspected during each year for proper equipment.

The following is a five-year record indicating the degree of efficiency.

|       | Trauma | Ambulance | Poor Trans- |
|-------|--------|-----------|-------------|
| Year  | Cases  | Cases     | portation   |
| 1950  | 8,176  | 4,317     | 23          |
| 1951  | 8,751  | 4,452     | 19          |
| 1952  | 9,187  | 4,855     | 17          |
| 1953  | 10,821 | 6,595     | 7           |
| 1954  | 10,846 | 6,383     | 3           |
| Total | 47,781 | 26,602    | 69          |

The following outlines the subjects presented in the special educational courses given through the local Red Cross (Flint). Elaboration is obvious. The subjects selected indicate the common types of injuries seen in the Emergency Receiving Department at Hurley Hospital. Lt. Leon Mills, Flint Fire Department, is the special Red Cross instructor in charge of this course.

#### Position of Victim

Keep patient in comfortable position, head level with body, until you know the nature of the injury.

#### Examination

1. Look for serious bleeding, stoppage of breathing.
2. Fractures: Find all and splint.
3. Dislocations: Pillow splint for comfort.
4. Burns: Cover area with sterile dressing.

#### Shock

Maintain body heat. Transport in supine position.

#### Control of Bleeding

1. Direct pressure over wound.
2. Know pressure points (six important ones).
3. Use tourniquet as last resort.
4. Place sterile dressing over all open wounds and bandage in place.

#### Internal Injuries

1. Maintain body heat.
2. Keep victim perfectly quiet. Move only when absolutely necessary and in supine position.
3. Turn head gently to one side if victim is vomiting.

#### Failure of Respiration

1. If victim is not breathing, start artificial respiration immediately (back-pressure, arm-lift method).
2. Use oxygen when victim starts to breathe.

## RESPONSIBILITY TO THE INJURED—CURRY

### Fractures

1. Splints should be used whenever a fracture is suspected.
2. Fractures may be either open or closed.
  - A. Closed Fractures.
    - (a) Arm fracture: Bandage arm securely over chest or use two wood or fibre board splints, one on each side of arm.
    - (b) Forearm fracture: Splint with pillow or use wood or fibre board splints.
    - (c) Wrist fracture: Wood or fibre board splints to palm and under side of lower arm.
    - (d) Femoral leg fracture: Thomas half ring splint with traction at ankle. Support splint so heel does not rest on cot.
    - (e) Lower leg fracture: Thomas half ring splint with traction at ankle. A pillow or padded fibre board splint may also be used.
    - (f) Ankle fracture. Pillow splint or fibre board splint.
    - (g) Back fracture: Transport in position as when found (face up or face down). PRESERVE NORMAL ARCH OF SPINE.
    - (h) Neck fracture: Traction (applied by hand) on head for neck fracture. Transport in supine position. BACK AND NECK FRACTURES SHOULD BE HANDLED VERY CAREFULLY. HEAD AND BODY AS ONE UNIT.
    - (i) Lower jaw fracture: Bandage under chin and over top of head to hold lower jaw in position against upper jaw.
    - (j) Pelvic fractures: Transport on back, bind knees and ankles together. Some cases may gain comfort by placing pillows under knee.
    - (k) Joint fractures and dislocations. Fractures of the joints should not be moved (elbow, knee, and ankle). Splint with pillow in position found.
  - B. Open Fractures: In an open fracture there is a connecting wound to the surface of the skin through which the broken bone sometimes protrudes. These fractures are often more serious than the closed type. Check for serious bleeding and shock. Wounds should be covered with sterile dressings, and the fractures splinted as in closed fractures or with pillow splints if they contain foreign material.

### Chest Injuries

1. Rib fractures: If no internal injury is suspected, patient may be transported on his back with head and thorax slightly elevated.
2. Inner chest injury: This may be due to rib fracture or external puncture.
  - (a) Cover sucking wound with sterile vaseline gauze so that the outer air cannot enter chest cavity.
  - (b) Place victim on injured side and make him as comfortable as possible.
  - (c) Sand bag areas showing paradoxical motion.

### Dislocations

1. Pillow splint for comfort in transportation.

### Burns

1. Cover burned areas with sterile dressings and bandage in place.
2. If large area of body is burned, wrap in clean sheet.

### Head Injuries

1. Cover all open wounds with sterile dressings.
2. Avoid pressure at sight of injury.
3. Transport victim in prone position.

### Emergency Receiving Department

The Emergency Receiving Department of any hospital should be advantageously located for the reception of patients. It is a nerve center. Active and supportive treatment should be readily available, and organization should be projected to expedite quick action. Efficient nursing supervision is mandatory and should be continuous for twenty-four hours. X-ray facilities should be immediately available at all times. A blood-bank is essential.

In hospitals with house staffs, it is strongly advised that an intern be assigned to emergency service duty full time for selected periods during his training. If there are residents, the intern should be advised to call on them for help whenever necessary as part of his general training. In hospitals without house staffs, selected members of the attending staff may be used.

There are certain prerogatives and limitations which must be projected by an organized educational program in any hospital having a house staff, irrespective of the size of the staff or institution. It is important that when a house officer asks for help, it be immediately available. Delays and indecisions in the problems of trauma surgery are dangerous. In hospitals having active attending staff organization, members should be assigned to active duty at regular intervals and available at all times. It is axiomatic that the patient should be considered as a whole. The patient with multiple injuries represents an acute complex problem and takes priority.

### Hospital Management

The patient and his injuries should be individualized. Over-all appraisal is mandatory, with consultation freely requested if necessary. Pride should not enter into such important deliberations. Serious osseous injuries may be definitively managed coincidental with associated injuries, provided the latter are recognized and under control, and the patient has been stabilized. Delay at this point may produce a deconditioning process and the golden opportunity passes.

Events in the history of a traumatized person should have close continuity from the time of injury to the time of discharge. These should include immediate roadside care, efficient transportation, careful emergency department manage-

ment, and proper and timely selection of definitive care. Operative and postoperative facilities in the hospital should be adequate and handy. Outdated equipment should be discarded. Frequent check-up of the armamentarium for the surgery of trauma is recommended. In hospitals where a great deal of this work is done, organization under the direction of a qualified surgeon is a *must* for the maintenance of high standards.

### Postoperative Care

Postoperative care must be of high quality to achieve desired results. Intense interest in this on the part of the surgeon in charge keeps the chain unbroken through the house staff, nursing personnel, ward helpers, and orderlies. Nutrition and food balance are obvious. Good bedside care is most important.

Regular conferences are an important part of the organization of any surgical section. *All* cases are seen. "One should be critical of successes and honest with mistakes."

Follow-up care, short and long term, concludes the story. It is not important where and how this is done *as long as it is done*. In larger hospitals with training programs for interns and residents, a regular follow up clinic is advisable. Results are evaluated and the patient is seen by the house and attending staffs. Further end results studies, in groups, complete the chain of events.

Hospitals without house staffs will be obliged to organize the attending medical men to carry out these principles. The surgeon in charge must see that his patient has all the advantages of good management according to simple basis principles.

### Education

Educational activities arranged for the profession are strongly recommended. Parts of any county society scientific program and hospital staff

meetings should be devoted to the surgery of trauma. Special symposia should be given at selected times during the year in various sections of any state. These can be arranged by local regional committees on trauma, or by a state committee member in those districts where committees do not exist. Diversification of subjects is recommended. The teaching of trauma in medical schools should be revamped, and clinical application of principles made available to undergraduates.

### Recommendations

1. The adoption of a City Ordinance requiring certificates of proficiency of ambulance attendants.

2. Educational programs for ambulance attendants in each community, sponsored by the county medical societies, local regional committees on Trauma, A.C.S. and hospital staff organizations. Education programs can be arranged through the local Red Cross by specialized organization or directly by the groups above mentioned. In those hospitals where there are house staffs, instruction can be given by the young men in training. In those communities where there are no hospital house staffs or no hospitals, members of the younger medical group should be delegated for this important activity.

3. A receiving department chart of cases admitted to record the quality of transportation.

4. Ambulances inspected twice yearly as to proper equipment.

5. A well-organized emergency receiving department and efficient organization for hospital care.

6. Regular follow-up management until patient is discharged.

7. The entire story placed in the hands of the proper individuals who will *work*.

### NEW ACHIEVEMENTS THROUGH COOPERATION OF SURGEONS AND RADIOLOGISTS

"With surgeons and radiologists working together in the new era of the experimental method, there is expectancy that we may reach goals that have until now seemed unattainable," stated Dr. Frederick A. Collier, of Ann Arbor, in an editorial entitled "The Debt of Surgery to Roentgenology," published in the February, 1956, issue of *The American Journal of Roentgenology, Radium Therapy and Nuclear Medicine*.

"Anesthesia and antisepsis . . . were necessary, funda-

mental techniques, but surgery could not enlarge its scope . . . without clear-cut objectives demonstrated by this startling new discovery," Dr. Collier pointed out.

"The great advances in surgery in recent years have come from the laboratory to the clinic. The radiologist has played an important part in all these advances . . . he has been a fruitful and stimulating companion traveling with us on all roads to solid achievements," Dr. Collier concluded.

# Anesthetic Management in Acute Emergency Situations

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**E**MERGENCY surgery for the *severely* ill or injured patient always has posed a serious challenge to physicians. The critical condition of such patients requires an accurate evaluation of their condition, hurried preparation for surgery, and very astute judgment as to how much additional stress they may tolerate. The ever present threat of mass calamity is indication that each of us must keep abreast with current advances in all fields of medicine and, in the light of these advances, constantly reformulate policies concerning the management of *emergency* patients. Just as gastroenterostomy has given way to gastric resection in the surgical treatment of peptic ulcer, so open drop ether has been supplemented by newer and safer anesthetic techniques and agents. It is the purpose of this presentation to outline the accepted modern anesthetic methods, agents and adjuvants employed in the care of the emergency surgical patient.

## Precursory Evaluation of Patients' Vital Physiology Accompanied by Simultaneous Corrective Therapy (First Aid)

The emergency patient often is in such critical condition that certain definitive steps are necessary to sustain his life. These steps must be taken before considering a diagnosis or evaluating the patient from the standpoint of anesthetic or surgical risk. Much of the first aid treatment outlined below will serve as preoperative preparation of the patient.

*The Airway.*—The airway may be partially or completely occluded by one or more of a variety of causes. Anatomic relaxation of the muscles of the jaw and tongue accompanying the unconscious state, derangement of the supporting bony and muscular structures, foreign bodies including blood and vomitus, laryngospasm resulting from injuries of the neck and brain stem,

fractures of the tracheal cartilages, bronchospasm accompanying physical and chemical irritation of the bronchial tree and laryngeal, bronchial and pulmonary edema, are among the more common causes of the obstructed airway.

Treatment of the obstructed airway is of immediate import. Endotracheal intubation with a cuffed Magill tube usually is the best method of effecting and maintaining a constantly patent air passage in the unconscious patient. In addition, inflation of the cuff will prevent further aspiration of foreign substances into the tracheobronchial tree. If the protective laryngeal reflexes are still active, it will be necessary to establish temporarily the continuity of the air passage by holding the jaw and tongue well forward and, if necessary, by inserting an oropharyngeal airway. The reflex activity of the pharyngotracheal mucosa then may be obtunded by translaryngeal anesthetization, after which intubation is easily accomplished.

Translaryngeal anesthetization is accomplished by the insertion of a 20 gauge needle through the cricothyroid membrane into the lumen of the larynx. Through this needle 2 cc. of 6 per cent solution of Cyclaine®\* is rapidly injected.

Tracheotomy should be resorted to if the attending physician lacks experience in rapid intubation. A cuffed kink-proof tracheotomy tube is preferable to the standard silver tracheotomy tube, especially if anesthesia must be administered subsequently. If the tracheobronchial tree contains aspirated materials, thorough suctioning, employing a specially designed long catheter,\*\* is indicated. By utilizing the curvature of the catheter, it is possible to aspirate selectively both main stem bronchi.

Bronchoscopy should be avoided in the seriously ill or injured patient since this procedure produces

\*Trade mark of Sharp and Dohme, Inc., for its brand of hexylcaine.

\*\*This is a Barbic plastic suction catheter designed especially for the University of Minnesota Hospitals by the C. R. Bard Co., Inc., Summit, New Jersey.

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considerable hypoxia in itself. Should it be mandatory to bronchoscope such a patient, the procedure should be well planned and well executed. A high flow of 100 per cent oxygen is supplied through the oxygen feed nipple on the scope. The procedure should be carried out in a lighted room so that the color and ventilatory exchange of the patient constantly may be observed. Any deterioration in vital signs necessitates an immediate withdrawal of the scope and ventilation with 100 per cent oxygen.

*Inadequate Ventilatory Exchange.* — Even though the patency of the airway be established, an inadequate ventilatory exchange may be present from a variety of causes. Respiratory paralysis is common following head injury, increased intracranial pressure, and injuries of the neck. A marked diminution in respiratory exchange accompanies pneumothorax, sucking wounds of the chest, blast injuries, and atelectasis. The distended abdomen and ruptured diaphragm result in a reduction of the respiratory tidal volume. Excessive doses of anesthetic agents and other depressant drugs are particularly prone to depress respiratory exchange in the severely ill or injured individual.

Concomitant with the establishment of a patent airway, one must initiate artificial ventilation by whatever means the situation dictates. A normal tidal volume and respiratory rate can best be effected by the application of intermittent positive pressure breathing. The simplest methods available are usually the most expeditious. Mouth to mask or mouth to tube breathing for the patient is considered to be the best technique in emergency situations. The Kreiselman bellows resuscitator is an excellent apparatus of extreme simplicity for use in effecting artificial respiration.

In the case of pneumothorax accompanying sucking wounds of the chest, it is essential that the affected lung be re-expanded. This is easily accomplished by holding the chest wound open and applying a positive intrapulmonic pressure of from 10-20 mm. mercury. It may be necessary, because of injury to the lung parenchyma itself, to instigate continuous intrathoracic suction. Distention of the stomach and upper intestinal tract may be relieved by insertion of gastric and intestinal suction tubes. Fowler's position is advantageous to respiration provided the circulatory status of the patient permits.

*Inadequate Function of the Cardiovascular System.*—The severely ill or injured patient is usually in a state of shock. The physiologic basis for this shock is not well understood and may be due to one or more causes—toxic, humoral, hemodynamic, and psychic. A patient may suffer from normovolemic shock due to extreme trauma, or he may be in a state of oligemic shock because of severe hemorrhage. In both instances the shock is a progressive vasoconstrictive reaction to a reduction in the central circulating blood volume. The chief effect of shock is failure of adequate tissue perfusion with resultant cellular hypoxia. The brain, heart, liver and kidney are the most susceptible organs to cellular anoxia.

Immediate correction of the state of shock is mandatory, since both degree and duration are of prime prognostic importance.<sup>1</sup> Rapid restoration of the circulating blood volume is accomplished by the establishment of an intravenous infusion through a 15 gauge needle. The selection of any vein for this purpose is satisfactory. Often the external jugular veins are visible and palpable when all others are in a state of collapse. A venous cut-down may be necessary. Shock due to hemorrhage is correctable by blood replacement. When blood is not immediately available, plasma or dextran may be used. Slight Trendelenburg position with elevation of the legs will increase the central circulating blood volume. Vaso-pressor agents are not always indicated in the conscious patient since such patients are usually in a state of marked *hyperexis*.<sup>2</sup> This simply means that their homeostatic response to both trauma and blood loss is so exaggerated that tissue blood flow is markedly decreased by the extreme elevation of peripheral resistance consequent to exaggerated arteriolar and venoconstriction.

Further complicating the picture of shock may be superimposed cardiac failure. Such failure is usually on the basis of hypoxia of the cardiac musculature. This condition is accompanied by elevation of the venous pressure, acceleration of the heart rate, dilatation of the heart, and a low arterial blood pressure. Rapid digitalization may be accomplished with 3 to 5 cat units of acetyl strophanthidin.\* administered intravenously.<sup>3</sup>

*Inadequate Stress Response.*—One of the most recent advances in the care of the severely ill or wounded patient is the recognition and treatment

\*This drug may be obtained from the Eli Lilly Co.

of the inability of such a patient to react to stress. Poor stress responses are likely to be seen in aged and chronically debilitated patients, those patients who have been subjected to long periods of mental stress and tension, and patients who have received ACTH or cortisone therapy within the last six months to one year. When illness or injury befalls these individuals their homeostatic response is minimal or absent, and they exhibit a gradual deterioration in blood pressure, pulse and respiration. They respond poorly to such resuscitative measures as transfusion, vasopressors, and cardiac glucosides. Treatment of this condition is simple and definitive. One hundred to 200 mg. of hydrocortisone will effect a marked improvement in the status of these patients.

**Pain.**—Of last consideration and least import in the first aid treatment of severely ill or wounded patients is the management of pain.<sup>4</sup> In general, these patients are either unconscious or so desperately ill that they do not experience pain *per se*. It is essential that the physician differentiate between the existence of pain and the presence of hypoxia resulting from either inadequate respiration or circulation. Patients suffering from pain not accompanied by tissue hypoxia are oriented, co-operative, and usually do not thrash around. The patient suffering from hypoxia is disoriented, does not complain particularly of pain, and manifests wild confusion.

Opiates and barbiturates are to be avoided until resuscitative measures have restored the patient to a near normal physiologic state. One of the chief dangers in the administration of these drugs to individuals in severe shock rests with the fact that the drugs are not absorbed from either the subcutaneous or intramuscular sites because of profound arteriolar- and venoconstriction. Delay in response to medications often results in further administration of the drug. Then when the condition of the patient improves, the arteriolar and venous channels open and large quantities of drugs are absorbed into the circulatory system at one time. This results in a state of extreme respiratory and circulatory drug depression. It should also be mentioned that these patients, by the very nature of their condition, have an increased sensitivity to anesthetics and narcotics. When these individuals have been returned to a near normal state, one may then control pain through the judicious use of drugs administered intravenously.

The doses should be markedly reduced and sufficient time allowed for achievement of maximum effect before repeating. In general, it may be stated that the type of patient discussed here rarely needs a narcotic.

Should one encounter overdosage of an opiate the antagonist, Nalline®,\* may be administered intravenously in increments of 5 to 15 mg. In the near future a barbiturate antagonist will be available. (This is beta-beta-ethyl-methyl-glutarimide.)

### Evaluation of the Patient as a Surgical and Anesthetic Risk

In evaluating a patient as a surgical and anesthetic risk, it is essential that we consider numerous factors: the severity of the illness or wound, the response of the patient to resuscitative efforts, the age and condition of the patient, the amount of surgical intervention absolutely necessary, and the time available for preparation of the patient are among some of the more important considerations. It also is necessary to take into consideration the complicating diseases and conditions not related to the immediate treatment.

**Response to Resuscitative Measures.**—The patient's response to resuscitative measures is often an excellent guide to the extent and nature of the operative procedure which may be undertaken. If the patient has had a good response, and his vital physiologic functions have resumed a satisfactory state, then one may assume that reasonably extensive corrective surgery can be accomplished provided careful attention is paid to hemostasis and avoidance of additional tissue trauma. If the patient's response to first aid measures was poor, only the most urgent surgery should be performed and any procedure which safely may be postponed until the patient is in better condition, should be deferred.

**Existing Disease Process Complicating Surgery and Anesthesia.**—Patients with a history of cardiac disease, pulmonary complications, anemia, liver disease and renal disease must be carefully evaluated.

#### 1. Cardiac abnormalities.—

(a) *Coronary artery disease.*—This entity presents many difficulties since it is a problem to

\*Trade mark of Merck and Company, Inc., for its brand of n-allyl-normorphine hydrochloride.

evaluate these patients accurately regarding their ability to withstand the stress of anesthesia and surgery. Obviously this type of patient is extremely sensitive to hypoxia. The myocardial circulation makes inadequate adjustments to reduced oxygen tension, leading to further myocardial ischemia. Hypotension on the basis of vasodilatation likewise is poorly tolerated despite the fact that the reduced peripheral resistance places a diminished demand upon the work of the heart. One cannot be certain at what point the reduced pressure will impair significantly coronary blood flow.

(b) *Hypertension*.—Uncomplicated essential hypertension gives little cause for concern unless there is evidence of damage to the heart, kidneys and brain. It is apparent that one must be prepared to combat any significant decrease in blood pressure with peripheral vasoconstrictor agents. However, if the blood pressure is maintained reasonably near normal, these patients tolerate anesthesia and surgery exceptionally well.

(c) *Congestive heart failure*.—Rarely is operative intervention mandatory in the face of congestive heart failure. Surgery should be postponed in the critically ill or injured patient suffering from pulmonary edema if at all possible. Correction of the failing heart and restoration of normal pulmonary function must be considered a part of the emergency first aid care.

## 2. Pulmonary disease.—

(a) *Respiratory acidosis*.—Frequently patients who have required acute resuscitative measures are in a state of respiratory acidosis. The duration and degree of acidosis markedly affects the future course of the patient. Rapid return of the severely acidotic patient to the normal state of acid base balance often is accompanied by a marked fall in blood pressure, cardiac arrhythmias, and sometimes ventricular fibrillation.<sup>5</sup> The concentration of plasma potassium ion rises rapidly as the blood pH is restored to normal.<sup>6</sup> Hyperkalemia is believed to play an important role in the production of ventricular fibrillation. When time and laboratory facilities permit, it is advisable to determine the patient's state of acid base and electrolyte balance.

(b) *Emphysema*.—Patients with severe emphysema tolerate depressant drugs and anesthetics very

poorly. These patients are usually suffering from a compensated respiratory acidosis and it is not advisable to upset their acidbase balance picture in any manner.

(c) *Asthma*.—Patients suffering from, or with a history of asthma, deserve special consideration. Many of the anesthetic agents are prone to precipitate bronchoconstriction and should be avoided. Pentothal, cyclopropane and extracts of curare are a few of the offenders. Antihistamine therapy (intravenous Benadryl®) may prove efficacious in the preoperative preparation of these patients. Isuprel®\* has proven to be an excellent bronchodilator free of the undesirable side effects which accompany the use of epinephrine.<sup>7</sup> Unlike epinephrine it may be used on patients anesthetized with cyclopropane. Decreasing the density of the inhaled gas mixture with helium is of considerable benefit in relieving the dyspnea accompanying asthma.

3. *Liver and kidney function*.—Many drugs depend upon the liver and kidneys for detoxification and excretion. Severely ill or injured patients (especially those who have suffered shock and have received multiple transfusions) exhibit a marked impairment of both liver and kidney function. When such patients are subjected to surgery and anesthesia, there is an increase in the incidence of postoperative hepatorenal failure. It is essential that we select anesthetic agents which do not further impair liver function or increase liver damage. Agents having little or no effect upon the liver are nitrous oxide, cyclopropane, ethylene and the muscle relaxants. Those having only slight effects upon liver function are the local anesthetics and ultra-short-acting barbiturates. Agents which markedly impair liver function and possibly increase liver damage are chloroform, ethyl chloride, trichlorethylene, tribromethanol, divinyl ether and diethyl ether. It should be borne in mind that the ill effects of any of the anesthetic agents are increased many fold if respiratory or circulatory hypoxia exist during their administration.

Patients with severe liver impairment may have a very low level of plasma pseudocholinesterase. In this instance it is wise to avoid the use of depolarizing muscle relaxants whose effect may be markedly accentuated and prolonged under these

\*Trade mark of Winthrop-Stearns, Inc., for its brand of isopropyl adrenalin.

conditions.<sup>8</sup> In addition, these agents are not antagonized by tensilon or prostigmine.

Prothrombin production is decreased when impairment of liver function exists or when the liver has suffered hypoxia. The clotting time will be prolonged in such instances.<sup>9</sup>

Renal function is altered by hypoxia, hypotension accompanying shock and stress of any kind. In addition, most general anesthetic agents depress markedly the formation of urine.<sup>10</sup> This depression in renal function appears to be related more to the depth of anesthesia rather than to the specific agent used. In view of this fact, it is essential that urgent surgery be conducted in the lightest feasible plane of anesthesia. Postoperative hypotension should be avoided since these patients are prone to develop a renal shut down at this time.

4. *Metabolic disorders.*—Certain diseases and conditions directly related to disturbances in metabolism warrant special attention.

(a) *Diabetes.*—Diabetes is profoundly affected by certain types of general anesthetic agents. The volatile vapors, ether being the most common, produce profound hyperglycemia and a marked reduction in liver glycogen. Cyclopropane, nitrous oxide, pentothal and the muscle relaxants are the most ideal agents for use in the presence of diabetes.

(b) *Addison's disease.*—This condition is rarely encountered. It is characterized by hypotension, hypoglycemia, and inadequate stress response. It is usually necessary to administer norepinephrine and/or hydroxycortisone continuously during the administration of anesthetic agents.

(c) *Pheochromocytoma.*—This condition is rarely seen. These patients exhibit a marked vasopressor response to both psychic and traumatic stimuli. The hypertension accompanying this tumor may be controlled by preoperative preparation with regitine.

(d) *Body temperature.*—It has recently been shown by d'Amour and Erickson that the environmental temperature plays an important part in the outcome of the severely shocked patient. They conclude that severely ill and injured patients will have a better survival rate at subnormal environmental temperatures.<sup>11</sup>

*Transfusion.*—Undesirable effects related to citrated whole blood transfusions are of primary consideration in the management of patients requiring urgent surgery.

Bunker<sup>12</sup> has shown that very high concentrations of serum citrate resulted following multiple transfusions to patients with liver disease and in all patients during extremely rapid and prolonged transfusions. Ionized serum calcium was depressed to dangerously low levels and severe hypotension ensued. He has suggested the avoidance of citrated blood wherever citric acid intoxication is a possibility.

The pH of stored citrated blood is in the neighborhood of 6.5. Our laboratories have demonstrated that administration of a single bottle of this blood will reduce a patient's pH from 7.40 to 7.25. The progressive hemolysis of bank blood also produces a significant rise in the plasma potassium concentration, so that multiple transfusions result in an increase in the plasma potassium level of the patient. Here, then, we have several factors involved in the production of an unfavorable state by citrated whole blood infusions: (1) Citrate intoxication leading to a reduced concentration of ionized plasma calcium; (2) production of metabolic acidosis; (3) elevation in the concentration of plasma potassium resulting from metabolic acidosis and increase in plasma potassium resultant from progressive hemolysis.

Crowell<sup>13</sup> has demonstrated an increased tendency for blood to clot in states of severe shock. This results in multiple thrombosis of the portal and pulmonary vessels. He has shown, in dogs subjected to severe shock, that the survival rate can be markedly improved by the addition of 5 to 10 milligrams per kilogram of body weight of heparin.

#### Choice of Anesthesia

Having considered the first aid therapy, preoperative evaluation of the patient from the standpoint of risk and complications, and having ascertained the extent and type of surgery to be done, one may choose intelligently the anesthetic agent and method of administration. Regardless of the technique of anesthesia employed, one must adhere strictly to a few general principles. The airway must be kept patent at all times. Adequate ventilation using elevated oxygen concentrations must be provided, and the alveolar car-

bon dioxide concentration kept normal. Every effort to avoid deep general anesthesia should be exercised.

**Conduction Anesthesia.**—Local infiltration and regional nerve block comprise the safest of all anesthetic techniques in either the acutely ill or severely injured patient. This method of anesthesia does not preclude the maintenance of a patent airway and artificial ventilation when needed. As previously described, the patient may be intubated under topical anesthesia, and artificial respiration supplied.

**Spinal Anesthesia.**—The severely ill or injured patient who has not fully recovered from shock is a very poor candidate for spinal analgesia. The ascent of a spinal anesthetic is accompanied by an ascending paralysis of the sympathetic fibers maintaining vasoconstriction. This in turn results in a precipitous fall in blood pressure. Under no circumstances should a patient in shock receive a spinal anesthetic. Spinal analgesia can be administered only when patients have been returned to a near normal physiologic state.

**General Anesthesia.**—When it is necessary to employ general anesthesia for urgent surgery, it is essential that certain general fundamental precautions be taken. One must assure himself that the stomach is emptied by gastric lavage followed by continuous Wangenstein suction. To safeguard further the patient from vomiting and aspiration, it has been found advantageous to insert a cuffed Miller-Abbott or Sengstaken tube into the stomach, inflate the cuff, and pull it back against the cardia. This prevents the regurgitation of stomach contents. Intubation should be performed under translaryngeal anesthetization and the cuff inflated prior to the induction of general anesthesia.

1. *Ether.*—It has been shown recently that ether is one of the less desirable anesthetic agents, a belief supported by a great deal of current research. Fisher<sup>14</sup>, using the dog heart lung preparation, has shown that cardiac failure with a marked diminution in cardiac output occurs when relatively low blood concentrations of ether are present. Johnson<sup>15</sup> has pointed out that reductions in cardiac output occur in man during ether anesthesia. More recently Brewster<sup>16</sup> of Massachusetts General Hospital has exploded completely

ly the assumption that ether acts as a stimulant to the respiratory and cardiovascular system. He has demonstrated conclusively that the so-called stimulating action of ether is not that of ether at all, but is the result of an increased liberation of epinephrine. Animals and man subjected to total spinal anesthesia, bilateral adrenalectomy or adrenal exhaustion exhibit a marked deterioration of the respiratory and cardiovascular systems accompanying ether anesthesia.

Studies on vascular homeostatic responses by Hershey and Zweifach<sup>17</sup> reveal that: "Ether administration resulted in extensive depression of these responses with sufficient vascular dilatation and endothelial damage leading to an early drastic limitation of these homeostatic responses."

The progressive production of metabolic acidosis accompanying ether anesthesia is a clearly established fact.<sup>18-21</sup> In a more recent study, Radford<sup>22</sup> has shown that the minute ventilation must be increased 20 per cent (lowering the PaCO<sub>2</sub> to 30 mm. Hg.) to compensate for this metabolic acidosis. Superimposed upon the metabolic acidosis of ether anesthesia is a respiratory component. This is the result of hypoventilation encountered in the deeper surgical planes of anesthesia and must be offset by constant augmentation of respiration. The ill effects of acidosis have been emphasized recently. Miller and Brown<sup>23</sup> have demonstrated the marked tendency for the development of ventricular fibrillation following sudden release from a state of severe respiratory acidosis. Campbell<sup>24</sup> has shown the increased activity of cardiac vagal effects accompanying acidosis. Young and Sealy<sup>6</sup> have demonstrated a marked rise in the plasma potassium ion concentration resultant from the production of acidosis. Further, they have demonstrated that correction of the acidosis results in an additional increase to sufficiently high levels of potassium for the production of ventricular fibrillation.

When one considers the effects of citrated whole blood transfusions insofar as the production of acidosis and elevation of the plasma potassium ion concentration, it is evident that ether anesthesia can only amplify these undesirable conditions.

2. *Chloroform, divinyl ether and trichlorethylene.*—Contraindications to the use of these three compounds are similar to those listed for ether. In addition, these compounds are a great deal more toxic and potent.

3. *Cyclopropane*.—This is one of the best agents with which to produce anesthesia in the urgent surgical patient. Of all the major general anesthetics, it is least likely to depress liver and kidney function, since it is not detoxified and excreted by these organs. It is also of considerable value since high concentrations of oxygen are administered with it. Some of the difficulties encountered in the use of this agent are its profound respiratory depressant effect and its potential for the production of cardiac arrhythmias. Patients anesthetized with cyclopropane require constant augmentation of respiration. The avoidance of cardiac arrhythmias is mainly a matter of adequate training in the use of this agent. Preoperative preparation with atropine, trans-laryngeal anesthetization and the employment of flaxedil as a muscle relaxant contribute significant protection against the production of arrhythmias.

4. *Nitrous oxide*.—This is an extremely safe analgesic when used with adequate concentrations of oxygen. It has virtually no effect upon the cardiovascular, respiratory and hepatorenal systems. Its greatest disadvantage rests with the fact that anesthesia sufficient to produce muscular relaxation may not be achieved.

5. *Pentothal*.—It has been recently emphasized that pentothal had been found to be one of the most useful agents for the anesthetization of battle casualties. It is stressed, however, that this drug must be used judiciously. In patients suffering from shock, pentothal must be administered slowly and in small dosage increments. The amount of drug required for the production of narcosis is markedly reduced in the severely ill or injured patient. It is further pointed out that major surgical procedures could be accomplished utilizing only a few cubic centimeters of 2½ per cent solution of pentothal for induction, followed by nitrous oxide and a muscular relaxant for the maintenance of anesthesia.

6. *Muscle relaxants*.—The use of muscular relaxants as adjuvants to anesthesia constitutes one of the greatest achievements of the past fifteen years. Many of the early difficulties encountered in the use of these agents have been rectified, e.g., the newer synthetic products are devoid of histamine liberating qualities, cumulative action, and hypotensive properties. Flaxedil is one of the

better muscular relaxants. It produces an increase in cardiac output, an elevation in blood pressure, an increase in pulse rate, and as mentioned before, possesses strong cardiac vagolytic properties. Its action is readily reversed by tension. In our institution, this agent has been employed in the treatment of tetanus and has been administered continuously for as long as thirty-three days without ill effect. Succinyl choline is an ultra short-acting muscle relaxant, its duration of effect lasting only three to five minutes. This drug is classed as a depolarizing agent, and should be avoided in the aged, chronically debilitated patient and in patients suffering from liver disease, since their plasma concentration of pseudocholinesterase may be low. Its action is not antagonized but is potentiated by tension or prostigmine.

7. *Chlorpromazine*.—Most recent among the adjuvants to anesthesia is chlorpromazine. This drug is a powerful potentiator of narcotic, soporific, analgesic and anesthetic agents. In addition, it has the peculiar property of diminishing the incidence of nausea, vomiting and hiccups. The anesthetic potentiating effect of chlorpromazine may be used to great advantage in the management of the urgent surgical patient. For example, abdominal surgery may be performed satisfactorily using a gas mixture of equal parts of nitrous oxide and oxygen and small doses of muscle relaxants when the patient has been prepared preoperatively with chlorpromazine. Since chlorpromazine has a hypotensive property of its own, it is necessary to prepare the patient by intravenous administration of 2 mg. increments spaced two to three minutes apart until from 10 to 20 mg. have been given. Using this technique, the blood pressure can be monitored constantly and precipitous falls avoided.

*Anesthetic Management of Some Common Emergency Surgery Problems*.—It is advisable to mention some of the more common anesthetic problems encountered in urgent surgery.

1. *Intracranial operations*.—Certain anesthetic precautions must be observed in the management of patients with head injuries or cerebral vascular accidents. These patients often show signs of increased intracranial pressure. The respiratory and vasomotor centers may be affected. Should the conduct of anesthesia result in further increase

in intracranial pressure, vasomotor collapse, respiratory paralysis, increased intracranial hemorrhage or rupture of an aneurysm is likely to occur. The induction of anesthesia, therefore, must be carried out in such a manner as to safeguard against any further rise in blood pressure. This is best accomplished by the administration of pentothal and a muscular relaxant in such quantity as to paralyze completely the patient. Following this induction dose, artificial hyperventilation is performed for a minimum of three minutes. The patient is then quickly intubated and hyperventilation continued. Careful monitoring of the blood pressure will reveal that frequently this type of induction and intubation produces a fall in pressure. In this particular instance, the hypotension achieved is desirable.

Following intracranial surgery, there may be a depression of respiration or even apnea, and certain protective reflexes such as coughing and swallowing may be obtunded. When these signs are present or anticipated, it is desirable that an elective tracheotomy be performed before the patient leaves the operating room. This precaution will enable nursing personnel to keep the tracheobronchial tree free of foreign material.

2. *Fractures of the jaw.*—Fracture of the jaw often accompanies multiple injuries incurred in automobile accidents. Since correction of the jaw deformity may necessitate wiring of the teeth, the attending surgeon is faced with one of two alternatives. He may postpone treatment of mandibular fractures in deference to the other injuries. When surgical treatment of these has been completed, mandibular immobilization may then be undertaken. If, however, the other injuries incurred necessitate several operative procedures requiring a period varying from a week to a month, it may be desirable to repair the jaw fracture at an early date. When the surgeon elects to do this, then he must perform a preliminary tracheotomy so that a patent airway will be assured for all future operations. Attempting general anesthesia (or even major surgery under spinal anesthesia) in a patient whose mandible is immobilized is extremely hazardous and can only be condemned.

3. *Injuries to the cervical spine.*—Some fractures and/or dislocation of cervical vertebra can result in spinal cord injuries, one must be particu-

larly cautious about intubation. Direct laryngoscopy and intubation often require considerable extension of the neck. Since such extension may result in cord injury, it may be desirable to attempt intubation blindly through the nasal route without disturbing the position of the head. Should blind insertion of the tube fail, it is often possible to insert the tube working with the MacGill forceps through the laryngoscope, without disturbing the position.

4. *Intestinal obstruction.*—Vomiting and aspiration during the induction of anesthesia in patients with intestinal obstruction constitutes one of the most common causes of anesthetic mortality, but at the same time, one of the most preventable causes of death. Preoperative decompression by continuous Wangensteen suction and endotracheal intubation with topical anesthetization, as previously described, completely circumvent this hazard.

5. *Burns.*—Anesthesia for the surgical treatment of burns requires no special consideration providing the patient has received adequate anti-shock therapy and the fluid and electrolyte balance are normal. In general, burns may be managed best under very light general anesthesia.

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# Accident Proneness

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ACCIDENTS resulting in death or injury are a matter of increasing concern in our society. Much thought and effort in the last two decades has resulted in a decrease of accident rates, but accidental fatalities still constitute the major single cause of death between the first and thirty-sixth years of life. More than 9,000,000 injuries, with at least a temporary total disability, are reported each year, and over 90,000 of these are fatal. The cost, direct and indirect, of accidents is estimated at about \$10,000,000,000 annually.<sup>1</sup> The social and economic importance of accidental injuries is increased further by the fact that so many young people and heads of families are affected. Of the various professions dealing with the problem of accidents, physicians have major interests in the prevention of fatalities, the diminution of permanent disabilities, and in the decrease of morbidity. Much of our work deals with the treatment of injuries but we also have contributed toward their prevention.

That efforts at prevention can be fruitful is exemplified in industry where such attempts have been most persistent. The industrial units reporting to the National Safety Council have shown a drop in injury and death rates to about one-third of what they were some twenty years earlier.<sup>1</sup> Various approaches in the fields of transportation and home accidents have shown at least temporary improvement, even though our knowledge of the causes of accidents was quite uncertain and the attempts at their prevention were largely empirical and often haphazard.<sup>2,3</sup> Much work has been done on the problems of accidents and over a thousand publications are available in this area. In general, the studies have been either statistical or clinical in nature. We have learned much of actuarial import and can tell fairly well what parts of the body are likely to be injured at what time of day or year, and we have a considerable amount of data in regard to a variety of

individual factors related to accident frequencies. There is, however, still a great deal of controversy and disagreement about some of the basic questions of causation. Evidence seems overwhelming for the conclusion that no single factor is the cause of any large group of accidents and that attempts to find a universal pattern for accidents are doomed to failure. A study of some 95,000 work accidents in 1952 indicated that in all but 5 per cent of these there was an "unsafe condition" of a mechanical or physical nature present, and that all but 5 per cent had some "unsafe act" of a personal nature associated with them.<sup>1</sup> Of these accidents, 90 per cent were judged to entail some combination of both external and personal factors. There is valid statistical evidence to show that accidents are related to such factors as intelligence, attitude, alcohol, drugs, morale, fatigue, or emotional stress; but the correlation of any one of these factors with accidents generally is relatively low and none could be used alone to explain the cause of accidents. The more complex and obscure factors of personality traits or emotional constellations of the individuals involved in accidents are difficult to deal with especially in any statistical study. Without an understanding and an evaluation of the personality or mental factors which might play a role in accident causation, however, no satisfactory program of prevention can be developed. We must ask and try to answer such questions as why an accident occurred at this particular time, although the "unsafe condition" was there all along; why to this particular person when others were exposed as well?; why some people have a disproportionate number of accidents?; and also why children guarded by some mothers suffer more injuries than others.

Though we assume that a number of external and personal causal factors, occurring in combination, are responsible for the vast majority of accidents, we cannot ignore the fact that most accidents also represent bits of human behavior, and that the behavior of people is related to their

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emotional states and their personality patterns. There are various indications in the literature that such temporary emotional states as anger, resentment, defiance, depression, worry, guilt, or tension are positively related to accidents. There are also studies suggesting that individuals with a history of repeated contacts with courts, social agencies, or credit institutions, or with records of traffic or disciplinary violations, are more apt to have accidents. People with a history of alcoholism, or of habitual use of self-administered drugs, appear also to be more liable to accidents. Finally, there is ample evidence that individuals who have had previous accidents are more apt to repeat in the future. Temporary disturbed emotional states are certainly more likely to occur in some individuals than in others. The more prolonged histories of agency contacts, conflicts with authority, or of habitual use of chemicals are even more clearly related to the personality of the individual. In connection with a study of vehicular accidents, Tillman & Hobbs said that "a man drives as he lives," and McFarland, who is generally skeptical of personality factors, finds much promise for prediction of accident liability in "style of life" indices.<sup>2,4</sup>

Over thirty-five years ago, a study of minor industrial accidents in Britain indicated that these were not distributed at random.<sup>5</sup> A study from Germany a few years later showed similar results.<sup>6</sup> Too large a number of individuals had repeated accidents while more than expected had none, although all were assumed to be exposed to the same risks. Since then various statistical investigations have supported and augmented the concept that some people have a propensity for repeated accidents or are "accident-prone." This concept has gained much attention from various transportation and manufacturing concerns as well as from most insurance companies. Accident repeaters have been weeded out or used in less risky jobs. One utility concern shifted its chief accident repeaters to nondriving jobs and reduced the rate of its vehicle accidents to one-fifth of its previous frequency.<sup>7</sup> The meaning of accident proneness has been interpreted differently by various writers. In some survey studies, it appears to refer to any one or more personal factors of the individuals who have more accidents than they are entitled to statistically, while in others "prone-

ness" is conceived of as a specific unknown or known basic personality trait which directly leads to accidents. Some apparently exaggerated statements have been made about accident proneness, such as that 10 to 15 per cent of the people are responsible for 80 to 90 per cent of the accidents in their group. More reliable seem to be the indications that accident habits tend to persist and to carry over to other situations or activities. Also, that the frequency of minor injuries parallels the individual's rate of major accidents. More recently new or recalculated statistical data was used to invalidate the claims of the great importance of accident proneness in the causation of accidents. In one extensive study it is called a "fiction of accident-proneness," apparently because an inherent specific personality constellation could not be statistically validated.<sup>2</sup> Elsewhere in this study, however, the evidence regarding "proneness" is called only scanty or "unfortunately equivocal," and the term "accident repeaters" is advocated instead.

Clinical psychoanalytic studies in the late twenties described patients with neurotic tendencies to punish themselves in response to their persistent unconscious guilt feelings. In two such patients described by Fenichel, accidents also occurred, though they are mentioned only incidentally.<sup>8</sup> In the thirties, several clinical papers dealt with neurotically determined accidents. These showed that some people suffer accident injuries for specific though unconscious mental reasons or that they hurt themselves "accidentally on purpose." Flanders Dunbar and her colleagues published the result of a study of a group of fracture cases which they had intended as a control for a group of coronary disease patients.<sup>9</sup> She was surprised to find a high rate of previous injuries and considerable psychic pathology related to the causation of their fractures. She treated her findings statistically and abstracted characteristic personality patterns for accident prone persons.<sup>10</sup> These were described as impulsive, independent, self-reliant, having a tendency to appear casual about their personal feelings. Their emotional situation at the time of the accident was often that of anger at authority and they showed guilt after the injury. As a result of this study, mainly, the term "accident proneness" assumed a more specific meaning in which purposiveness and even a specific dynamic conflictual mental pattern was assumed to be present.

\*Greenwood & Hobbs coined the term "accident-prone."

The clinical studies of individual patients, particularly of those with a number of accidents, are particularly convincing in showing that some individuals take an active and apparently purposive part in the production of their accidents. Karl Menninger described a patient who had twenty-four major accidents, including the wrecking of eleven automobiles, in whom guilt over hostility to others led him to seek expiation through hurting himself.<sup>11</sup> A similar emotional situation existed in a thirteen-year-old boy whom I saw after he had had many accidents, including four which caused major fractures and an amputation of an arm. He also had a record of delinquency and was later convicted of a slaying. How close anger at oneself is to hostility toward others is exemplified here. I also saw two young women with the symptom of compulsive self mutilation, one through the use of burning cigarettes and sharp instruments, who gave a previous history of many minor accidents, and the other, who mostly used her finger nails during sleep and who had managed to hurt herself accidentally by a fall or a sprain whenever she and her family succeeded in preventing her scratching by tying her arms for the night. In both, strong unconscious demands for solicitude, as well as much unconscious guilt, were present, together with a more obvious resentment of their parents. While the unconscious need to punish oneself in order to alleviate guilt is the most commonly described motivating factor in accident proneness, other emotional situations may play a role. At times the injury to oneself appears to be an attempt to forestall a worse punishment or to gain permission to indulge again in forbidden fantasies or acts. Accidents may serve as a means of gaining affection and dependent care, and this purpose may later be continued in a compensation neurosis. In some children the injury seems to have the purpose not only of gaining love but also of punishing someone close to them, in whom they are disappointed and whom they want to make sorry.

The occurrence of a specific accident in an individual who has a persistent psychologic need for it may be precipitated either by the presence of an opportune situation which he then utilizes or by a temporary increase in the need to expiate a sin or to gain some other advantage for himself. All of this happens, of course, without any conscious awareness of the patient and in

spite of his conscious efforts. Concern over a sick child or an unhappy wife which is associated with guilt, or an impulse to do something prohibited by the person's conscience, are typical examples of what might accentuate the need for an accident. Some of these patients may have many minor accidents such as cuts or abrasions without stopping to pay attention or being able to remember the incidents. We see patients with similar guilt or self-punitive tendencies who manage, instead of accidents, to get repeated surgery. Others make themselves suffer through psychogenic illnesses or by repeatedly spoiling all imminent successes in their life. Aside from a basic need for self-punishment in accident repeaters, clinical findings indicate that these patients are also likely to have a general tendency to act-out their problems. They are described as impulsive, active individuals who deliberate little and do not talk easily about their emotions or inner problems.

Just how important the personality or emotional characteristics of the individual are in the vast number of accidents is still very much in dispute. We do not as yet have reliable psychologic tests which can help us to predict the individual's accident potential. Clinical psychiatric examinations of pilots has been reported of value. A close contact of flight surgeons with pilots with the aim of preventing dangerous missions of pilots under unusual emotional stress has been used as a means of diminishing accidents. So far, a history of repeated accidents in the past, whether minor or otherwise, and evidence of an aggressive, impulsive or unstable pattern of life seem to be the most reliable criteria for predicting accidents in the future. Whether accident-proneness is a major or relatively minor factor in accident rates we do not know at present, but that accident-prone individuals exist is certain, and that they need to be considered in the problem of accident causation seems obvious. Better methods and tests are needed to find and evaluate the accident liable individual. These could lead to a better understanding of the problem of accidents and to more rational programs of prevention.

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# Prevention of Accidental Trauma

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WE are all aware of the remarkable achievements in disease prevention in the past several decades. Vaccines and antibiotics have made preventive medicine a reality in everyday practice. As a result, most infectious diseases can be controlled and some have been virtually eliminated as major causes of death. With these medical triumphs, new health problems have emerged to command the attention of the medical investigator, the health officer and the practicing physician. One such problem, accidental trauma, is of staggering proportions.

In 1954, 89,432 Americans lost their lives by accidents. Only cardiovascular disease and cancer deaths now exceed those due to unexpected injury. Accidents are the leading cause of death from ages one to thirty-five; second to heart disease in the age group thirty-five to forty-four; and outranked only by cardiovascular disease and cancer among persons forty-five and over. In contrast to cancer or circulatory disease, accidents frequently take the lives of many in childhood or in their prime.

## The Menace of the Machine

An important factor in the accident problem is the machine. In 1954, 35,586 Americans were killed, and about 1,250,000 were injured in automobile accidents. Farm accidents due to increasing mechanization of the farm are all too common. Industry has made great progress in protecting man from the hazard of machinery; nevertheless, in 1954, 14,000 workers lost their lives from accidents on the job. The home, almost as mechanized as a factory, especially with the growing popularity of power tools for home workshops, is nearly as dangerous as the highway. In 1954, 27,500 persons died in home accidents. The machine, a proud symbol of our modern age, is

now almost as great an environmental hazard to man as bacteria.

Like the visible portion of a towering iceberg, these statistics are but a small part of the total picture, revealing only a fraction of the total social and economic loss. For example, the value of property destroyed and damaged by traffic accidents in 1954 is estimated at \$1,600,000,000 and all costs, including medical expenses, were \$4,400,000,000. For every fatal accident, it is estimated there are at least 100 serious enough to cause disability for a day or more. If we consider all United States battle casualties in World War II, the number of those killed, wounded, and taken prisoner combined was about one-eighth of the accidental injuries in this country in 1954.

These facts mean that treatment of accidental trauma is an important and growing part of a physician's practice. But until recently, the prevention of injuries has not occupied the attention of any large segment of the medical profession. Prevention has been left to safety organizations. The National Safety Council and its state and local affiliations are doing a fine job, especially in public education, in industry and through the schools, farm organizations and highway safety programs. But the National Safety Council has been among the first to indicate that this country cannot have a comprehensive accident prevention program without the active participation of organized medicine and public health agencies.

Because, as physicians, you so often see the brutal and tragic results of accidents, you can also see the need for more adequate study and control of this waste of human and material resources. By your training as well as experience, you can, if you will, make important contributions to accident prevention. Prevention must be based on adequate knowledge, but accident research is not yet well developed. Knowledge about the cause of accidents is somewhat comparable to our knowledge of disease etiology a century ago. Then, diseases were identifiable, but exactly why and how an individual became ill and died was largely un-

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known. Today, too little is known about the circumstances which lead up to and precipitate accidents. Even less is known about such important influences as the health, personality and behavior of people who have accidents.

The need to focus on the individual is one of the most important reasons for physicians to participate in safety programs. By training and experience, the physician is best equipped to judge the importance of physical and emotional factors which may contribute to accidents. Because the physician has the responsibility for treating the accident, closer co-operation between safety authorities and the medical profession in the investigation of how and why it occurred is necessary. Physicians can also contribute by community leadership and instruction of patients concerning common accident hazards.

The two age groups with the highest accident fatality rates are the very young and the very old, and most accidents in both these age groups take place in or around the home. Both are outside the influence of the organized safety work carried on by schools, industry, and highway safety groups. The physician, as family health counselor, is well qualified to take the leadership in studying and working to prevent accidents to those under five and over sixty-five years of age.

#### Education

The physician as family counselor in child rearing has the opportunity and the responsibility to include accident prevention advice in the health supervision program for the child. This advice has been likened to a new vaccine to be offered—but it is an immunization to be given to the parents rather than the children.

The "vaccine" is intended to increase parents' knowledge, understanding, and confidence in child management and care. Its administration should be timed to help parents anticipate risks for which reasonable precautions can be taken at various stages of development. Accident prevention education handled in this way becomes a natural part of the child-rearing program and is not likely to produce attitudes of anxiety, fear, and overprotection. The "dose" and the "technique" of safety education are matters of professional judgment. The child's personality, his muscular co-ordination, his physical environment, and the parents' emotional attitude toward the child and the doctor, are factors which determine *what*, *when* and *how much* should be given.

To help the physician in determining the "dose" and the "technique" there are many suggestions by authorities in this field. For example, Press has proposed that physicians give parents a home safety check list about the time the child is eight months old. At this age, the accident hazard begins to increase. A check list on home and child safety may be obtained from the local health department or safety council. Such a list, presented to the mother, taken home, filled out carefully and at a subsequent visit discussed with her, will do much to impress the whole family with the importance of the subject. The Children's Hospital of Boston has published a useful booklet on the prevention and first aid handling of pediatric emergencies which every home with children should have. The Cincinnati Children's Hospital also recently published an excellent pamphlet on this subject.

When the physician makes a home visit, there is opportunity for education, too. Finding and advising corrective measures for such accident breeders as a carelessly placed roller skate, a medicine cabinet easily accessible to little hands or an unguarded stair or window may be as significant a contribution to preventive medicine as recommending the removal of a pair of diseased tonsils. Such "environmental inspection" is an effective way to educate. Most people must have their attention directed to hazards before they recognize them.

We have no accurate information on the number of physicians who give child safety instruction to their patients, but from the interest in these publications just described we believe it is increasing. Eighty-five per cent of the membership of the American Academy of Pediatrics reported to our committee that they now give such guidance as a part of health supervision. We find that some physicians have their own child safety check lists; some use a bulletin board where they post news clippings of accidents or other material.

Children are not the only age group for whom safety education is important. The physician should keep in mind also the hazard to which the housewife is exposed, especially in her workshop, the kitchen. Men, too, are prone to injury in the home, especially in connection with home repairs. Special precautions should be taken by the elderly and those who are supervising their care to prevent falls. In other words, the safety "vaccine" may be used in all ages. To sum up its

use in everyday practice, there are five factors which must be considered if we are to develop a satisfactory "titre" of accident "antibodies."

1. We have to know the common or likely hazards at certain months or years of age. We have some data on this but need to accumulate more through research. We must develop effective means of discussing these hazards with patients in a manner which will encourage constructive action without creating unnecessary fear or alarm, or, equally important, feelings of guilt if a serious accident does occur.

2. We must be familiar with characteristic behavior and drives at certain ages.

3. We must point out the effect of a disregard of safety practices on the part of the adults. The value of a good example to children cannot be overestimated.

4. We must know the physical, emotional and intellectual capacities of the patient.

5. We must know the environment, not only the physical setting, but the emotional climate in which the individual is living.

### Community Service

Another important aspect of the accident prevention program is community service. An increasing number of physicians are active in their local safety councils and are also co-operating with other community groups. At our Committee headquarters in New York not a day goes by that we do not get a request in our office from a practicing physician for speech outlines and slides we have prepared for use with professional or lay audiences. These talks to lay groups are impressive examples of public service by the medical profession. Accident prevention is an ideal subject for the public education or public relations program of a medical society.

### Investigation and Study

In order for safety education to have significance, considerable knowledge must be accumulated about accidents in the community. A study of the frequency and types of accidents in one's practice or of those admitted to the emergency room of the hospital may be the starting point. How these contribute to the development of a program is illustrated by our experience.

A survey to secure more information on certain types of accidents in pediatric practice was made among the 3,000 members of the American Academy of Pediatrics. Half of the case reports received were due to poisoning; thirty per cent were cases of burns.

### Childhood Poisoning

Nearly 500 deaths due to accidental poisoning in children are recorded annually in this country and the mortality reveals only a fraction of the problem. For every child death from poisoning, there are probably more than 100 cases serious enough to be brought to a hospital. Most of these poisoning deaths in children are at ages under five years, the great bulk concentrated between the ages of one and three.

The difficulty of diagnosing some poisoning and the possibility that other causes of poisoning are being overlooked have led us to the conclusion that in large population centers satisfactory facilities for toxicologic examinations should be available to all physicians. The increasing use of new chemicals for insecticides and other purposes in our daily living increases the need for this special laboratory facility. Equally important is the need for a poison-information center where the doctor in an emergency can get advice on the possible toxic agent in a proprietary product and advice on therapy. With the aid of these facilities, practicing physicians as well as hospitals would be able to practice more scientific medicine not only in children but also in adults, especially those who may be exposed to toxic chemicals in their work.

Another aspect of the poisoning problem which calls for organized action is more informative labeling. In an emergency, the family as well as the physician may be working in the dark or even lulled into a false sense of security if the product swallowed by the child gives no hint of potential danger by misuse.

In adults, too, drugs are probably underestimated as a factor in accidents. This might well be the subject of study by an accident prevention committee of a medical society. Sometimes an uninformed individual undertakes self-medication with an unfamiliar potent drug. He may think if one dose is good, two doses are twice as good. Or he may take a drug under the wrong circumstances and end up not only accidentally intoxicated, but also involved in more disastrous situations. Bromides, alone or in combination with

barbiturates, or alcohol or chloral hydrate, seem to be common types of dangerous self-medication.

### Burns

We have mentioned burns as the other area of study and action which has grown out of our survey of accidents in pediatric practice. Our survey revealed that 30 per cent of all cases reported were burns; 60 per cent of these were associated with flammable clothing. Burns are the second most frequent cause of fatal home accidents and account for about one-fifth of the total. Colebrook found that 70 per cent occurred in children under fifteen, and 53 per cent in children under five years of age. This study made in England on 2,000 consecutive burning and scalding accidents admitted to the Birmingham Accident Hospital showed that two factors were largely responsible for the seriousness of the burns: (1) contact with an unguarded fire, and (2) ignition of clothing.

There has been insufficient study of the relationship of flammability of clothing to burns. Only when there are sensational episodes, such as the cowboy suits a few years ago and the torch sweaters recently, is the public made aware of the relationship of clothing to burning accidents. With the increasing use of synthetic fibres in clothing, it would appear more important than ever to prevent, by suitable pretesting, the sale of dangerous fabrics, especially for use in making children's clothing. In burn injury cases, a sample of the clothing should be obtained if possible and subjected to a flammability test. A standard method for testing has been developed.

### Traffic Safety

It is shocking to discover how little evidence we have on the relationship of physical or emotional impairments to traffic accidents. The medical profession, through appropriate authorities and committees, might give more study to physical and emotional health of the 72,000,000 licensed drivers in the United States. Again we need to pay special attention to the young and the old. We cannot ignore the fact that the highest traffic accident rates are in youthful ages. Since 1933, while the death rate from motor vehicle accidents in persons age five to fourteen declined about one-third, in those fifteen to twenty-four it has increased almost 50 per cent. Young drivers are a danger not only to themselves but to others. Chronologic age is not a criterion of maturity, either in judgment or skill, and studies should

be made to determine the value of certain types of physical and psychologic examinations to this problem. At the other end of the spectrum is the aging driver. It is not uncommon to see news items of auto accidents in which an elderly driver is reported to have lost control of the wheel and died of a heart attack while driving.

### Preventive Measures

We believe the time has come for the medical profession to assume a role of leadership in the prevention of accidental trauma. We suggest that the component units of organized medicine form committees to develop and carry out accident prevention programs in co-operation with other appropriate and interested agencies. The program ought to embrace all age groups but be focused where the results may be most fruitful. This appears to be at the beginning period of life, not at its terminal stages—though these should not be ignored. Such a program might embrace the following ten points:

1. Determine the magnitude of the problem in the community.
2. Learn what is being done about it.
3. Decide the special contribution of organized medicine in solving some of the problems. In this connection, the role of the Women's Auxiliary should not be overlooked.
4. Give particular attention to safety in hospitals and office practice.
5. Co-operate with those who are trying to enforce safety laws and to develop such laws.
6. Plan medical society meetings, e.g., using accident cases to emphasize causes and means of prevention.
7. Encourage more accurate and complete accident records and death certificates. Histories should include how and why the accident occurred.
8. Develop centralized information service for poisoning emergencies and toxicologic examination.
9. Teach patients safety, urging special caution in presence of physical or mental impairments.
10. Urge physicians to practice safe habits themselves.

Medicine and public health have played major roles in the battle which man has been waging

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## New and Old Methods of Managing Burn Wounds

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I SHALL begin with three vital statistics. The first concerns the relation of depth of burn to survival. A partial burn which does not require skin grafting has about one-half the killing power of a full-thickness burn of equal area. Unfortunately, unless burns are extremely deep, one cannot classify them on clinical grounds with authority at the time of injury. Last month a preliminary report to the Detroit Surgical Association by Dr. James Bennett of the University of Michigan, however, indicated that a differential in the takeup of radioactive phosphorus distinguishes deep partial from full thickness burns.

The second statistic concerns the influence of age upon survival. At age 30 the tolerance begins to fall—at first slowly, then sharply. While we all accept the proposition that increasing age brings increasing surgical mortality, this curve seems particularly stark.

The third statistic is that in the past fifteen years, there has been no decline in the mortality from full-thickness burns of over 35 per cent. Although many patients live longer, the ultimate survival rate is unchanged. Some patients with 90 per cent burns have been kept alive for three somewhat meaningless weeks. It is obvious that the therapy of shock has far outstripped the remainder of our therapeutic armamentarium. An important advance in our understanding has been the realization that when burned patients are toxic, the probable cause is a state of systemic bacterial invasion; culture of the blood will provide the evidence.

What, now, are the focal points of interest about burn wounds? There is a growing interest in studying, and perhaps influencing, the factors that determine the extent of tissue death following burns. The skin is a good insulator and heat is not readily transmitted through it. Perhaps death of the deep portion of the skin may occur as a complication of the burn rather than only because it is irreversibly cooked. It is possible that if vascular stasis and thrombosis, lym-

phatic blockade, and increased capillary permeability were less severe, tissue death would also be less extensive. Evidence from experimental burns in animals suggests that heparinization decreases tissue death, as it does in experimental frostbite. It has long been recognized that immediate immersion of burns in cold water relieves pain; last year, however, Price demonstrated that a reduction in tissue death is probably also brought about. That the application of cold water immediately after the burn will diminish edema and altered capillary permeability is graphically illustrated by a repetition of one of Price's experiments. A protein-bound blue dye escapes from the circulation to a far lesser degree about the burn that is immediately sluiced with cold running water.

Unquestionably, the unsolved problem in burns is the control of infection. Not only do many patients die because of invasive infection and septicemia, as already mentioned, but local infection also has devastating consequences. The control of infection in the presence of dead tissue and in the absence of circulation is an old riddle.

Because antibiotics, antibodies and leukocytes cannot arrive into the dead tissue, physical factors controllable by the physician assume an important role. In dying arteriosclerotic extremities, dry gangrene is generally free of infection, while wet gangrene tends to be infected. Dryness, coolness and light successfully provide a prophylaxis against infection where antibiotics have failed. The open or exposure treatment of burns endeavors to produce a dry gangrene of the burned tissues. Both clinical experience and animal experimentation have shown that healing is more rapid and infection less common in suitable burns treated by the exposure method than in burns treated with closed dressings. Please note, however, the reservation in the phrase, suitable burns. It is difficult to prevent cracking of the eschar about burned joints. If infection develops and dissects beneath the eschar, the eschar is transformed from a protective armor to an undrained

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pus bag. Circumferential burns of the trunk generally become macerated, however frequently the patients are turned. We have tried Farmer's suggestion of applying aluminum powder to the bed clothes and to the burn. This behaves as a solid lubricant, like graphite, and prevents the patient from sticking to the sheets; however, it does not do a great deal to aid drying of weight-bearing surfaces.

Since full thickness burns are healed only after they are grafted, and can be grafted only after they have been debrided, it is important to discuss debriding and grafting techniques. A crowning contribution of the exposure management of burns has been a facilitation of surgical debridement. Twelve days after the burn, there is a sharp line of demarcation between the dry leathery eschar and the living tissue beneath. The eschar is not associated with the intense inflammatory reaction and granulation tissue that are found beneath closed, vaseline-dressed burns; unless the underlying fat is also burned and liquefied, this reaction grips the dead skin and makes debridement arduous and more bloody. Precise scalpel dissection in the plane immediately beneath the eschar is satisfactory, although tedious. A new, flashy method is to employ the electric dermatome, set to cut at an appropriate depth. This is suitable only on broad even surfaces with an underlying fat pad to protect fascia and tendons. Its advantages are speed, reduced blood loss and a machine-tooled smoothness of the exposed surface.

The only comment appropriate to the subject of chemical and enzymatic debridement is that at the present time they have little to offer. Active enzymes are available; the difficulties lie in cost and in techniques that will continuously deliver active enzyme to large areas of interface between dead and living tissue. Our own experience has been limited to a retreat of acid debridement.

On the subject of grafting, it may be said that both surgeons and skin show an almost infinite adaptability; the result is that there are a very large number of successful grafting techniques. If granulation tissue is firm and bright red, it is not necessary to pare it before grafting. If one does decide to pare it down to its yellow-white base, however, better methods than scraping are available. The electric dermatome, set to cut at ten-thousandths of an inch, and advanced extremely slowly, performs this task magnificently also. A

surface as smooth as polished marble results. An old-fashioned straight razor is also useful. Assuming healthy granulation tissue free from serious infection, there are two major enemies to the take of skin grafts—hematoma and movement. With co-operative or immobile patients, we have found that it seems easier to protect the grafts from shearing stresses by the expedient of allowing nothing to touch them than it is to dress them with a perfectly immobilizing bandage. The completely open management of grafts also has a special advantage; one can care for the grafts several times a day if it is indicated. Hematomas may be evacuated so that the grafts re-establish contact with living tissue. Infected pockets beneath the graft may be opened, thus preventing dissection of pus beneath the surrounding graft. A diffuse infection of the entire graft can be immediately diagnosed, so that antibiotic soaks may be instituted.

Dr. James Barrett Brown in recent years has emphasized the importance of applying homografts to extensively burned patients until such time as their grafting may be completed from their own donor sites. He has made two additional points: first, that satisfactory viable skin may be removed from refrigerated cadavers for twenty-four hours post mortem; second, that this skin may be readily stored in nutrient media in the refrigerator for three months. Thus, any hospital in which patients die and which is equipped with a refrigerator, may have a skin bank, if it so desires. Although homografts generally persist only three to six weeks, repeated sets may be applied. They may be laid on as narrow zebra stripes alternating with stripes of the patient's own grafts, which will grow out as the homografts resorb.

I should like to comment briefly upon hormone therapy and upon food. Hydrocortisone applied locally to experimental burns has been shown to increase the amount of necrosis. Administered systemically, it has the advantage of slightly prolonging the survival of homografts; its disadvantages lie in electrolyte and protein disturbances and in greater susceptibility to infection and to gastrointestinal bleeding. We rarely employ the drug. The growth or somatotrophic hormone may, in the future, prove important. Studies to date indicate that it is helpful to the patient's nitrogen balance if the diet contains large amounts of protein; its effects are reversed when the protein intake is small. The relation

of the burned patient to his food is of considerable interest. Moyer has shown that rats on a protein-free diet close their burn wounds as rapidly as rats receiving a high protein diet. This study demonstrates the aggressiveness of an area of injury in the breadline for available amino acids, and it is entirely comparable to the salamander who can replace an amputated limb while deprived of food of any kind. However, it is not intended to prove that the patient as a whole does well without protein! During the first week after an extensive burn, gastrointestinal upsets are the rule, and we make no particular effort to provide an adequate diet; thereafter, however, we work at it earnestly. Generally, we employ the method devised by Dr. James Barron at the Henry Ford Hospital—the continuous pumping of a homogenate of an enriched hospital diet through a small nasogastric tube.

One of the difficult problems in managing severely burned patients is in setting the proper pace. Operative procedures that are few and

far between may allow infection and malnutrition to get far ahead. On the other hand, early, extensive, and closely-spaced surgery may kill the patient.

Where do our hopes for improved results in burn care lie? First, in mitigating the destructiveness of burn injuries—perhaps by heparin, cold applications or parenteral trypsin. Second, in controlling infection more successfully—perhaps by closed techniques that also dry the slough, perhaps by supporting the patient's resistance to invasive infection by the administration of non-specific bacterial antibody such as properdin. Third, in influencing the immune reaction that brings about the rejection of homografts, so that they may persist longer or indefinitely.

In all three of these categories some progress is now underway. In the meantime, it may be worthwhile in considering materials that may be applied to burned surfaces to recall Dr. Brown's statement, that the best grease is elbow grease. Even mediocre care of extensively burned patients calls for an extraordinary outlay of man-hours.

## ANESTHETIC MANAGEMENT

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# Management of Injuries to the Genito-urinary Tract Associated with Pelvic Trauma

By William C. Baum, M.D.  
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TO those of us interested in statistics it is apparent that highway morbidity and mortality figures for the past ten years make similar advances in the stock market pale by comparison. The magnitude of the problem faced by the hospital and physician responsible for the care of the acutely injured patient is proportionate to these statistics. Interestingly enough, it is not a problem confined to the metropolitan area alone—it exists wherever a road and an irresponsible or incompetent driver combine to form a unit of hazard of undetermined potential. The wailing ambulance may indiscriminately deposit the victims at the office door of the country practitioner, at the ambulance entrance of the village dispensary, or in the emergency room of the busy city hospital, whichever may be most convenient at the time. In effect, this makes every physician a potential traumatic surgeon.

It is impractical, of course, to consider every doctor, irrespective of training and experience, as qualified to deal with all aspects of trauma. It is not too much to expect, however, that he be familiar with routine methods of care and investigation of the acutely injured patient. This expectation is not simply a reflection of an alarming increase in traumatic work on a local level, but is born of a vital need for such knowledge on a national scale.

While it is agreed that the generalist has a preliminary responsibility in the care of the injured patient, and this responsibility may consist of such life-saving measures as correction of shock and maintenance of hemostasis, as well as subsequent investigation of the degree of damage by physical and roentgenographic survey, the specialist also has a responsibility, namely, to keep in mind that the confines of his interest do not necessarily limit the extent of the patient's damage. The individual with an open fracture of the femur and a crushed pelvis may also have an extensive laceration of the bladder. Likewise, extensive

contusion of the kidney may accompany a ruptured spleen or liver.

With these facts in mind, a discussion of specific injury of the lower urinary tract therefore must include the patient as a whole.

The genitourinary apparatus and lower urinary tract are especially prone to injury; the former by reason of its exposed situation anatomically in the male, and the latter by reason of its peculiar method of fixation, i.e., a vesical neck and prostatic urethra firmly fixed to the membranous urethra at the urogenital diaphragm with an expanding fluid-filled bladder sitting relatively unsupported above. The urethra and cavernous tissues, by contrast, are firmly secured in a tight fascial envelope called Buck's fascia. An additional fascial barrier has similar origin at the U-G diaphragm, but extends into the scrotum as Colles' fascia and on around the penis up onto the abdominal wall, where it is continuous with the fascia of Scarpa.

It is helpful to divide consideration of trauma, using the fixed barrier of the U-G diaphragm as the point of reference into sub-diaphragmatic and supradiaphragmatic injury.

If the injury is largely external and the barrier offered by Buck's fascia is not broken, the extravasation of blood and urine which ensues will be limited and will appear as a fusiform swelling of the shaft of the penis; while, if the injury is more extensive, the continuity of Buck's fascia may be lost. Escaping blood and urine will then be limited by Colles' fascia only, permitting extravasation to the scrotum and up onto the anterior abdominal wall.

In a case where traumatic extravasation involves both penis and scrotum, indicating rupture of Buck's fascia and extension of the escaping fluid to the barrier offered by Colles fascia, the therapeutic measures immediately indicated are: (1) deviation of the urinary stream by suprapubic cystotomy, (2) incision and drainage of the sites of extravasation, and (3) debridement of the periurethral tissues and reconstitution of

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urethral continuity by suture, or in extensive laceration by an indwelling splinting urethral catheter.

Tissues tolerate extravasated blood and urine poorly, even if uninfected. Healing takes place by extensive inflammatory reaction with scar, urethral stricture, and urethro-cutaneous fistulae. An untreated patient may develop massive lymphedema and chronic purulent tissue response. On lifting the penis, numerous urethro-cutaneous fistulae are often seen. Injuries of this type rarely escape notice, even though they may not be properly treated at first.

The second category of trauma by contrast, is not so evident, for here injury is supra-diaphragmatic, out of sight and, unfortunately often out of mind. The patient with these injuries is usually brought into the busy emergency room on Saturday night, in shock, with multiple extremity fractures, a chest wound or other distracting factors. He deserves and gets quick attention, but unfortunately his survey is often one-sided. His shock is treated, x-rays of his fractures are made, and he is then quickly taken to the operating room for the skilled attention of the orthopedist. As a rule, no one inquires as to the patient's ability to void and, if this function is not impaired, whether hematuria is present. No one does a rectal examination to see if there is a large bulging pararectal hematoma. Yet, failure to do this may cost the patient his life. I have seen a patient literally bleed to death into his pelvic cavity while his physicians were busily engaged in the problem offered by extremity fractures.

Rupture of the membrano-prostatic urethra is a very common and very serious accompaniment of forceful injury. The large vascular plexuses torn free by this injury quickly fill the pelvis with blood, the bladder lifts free of its attachment, and urine empties into the same space. To suspect its presence is to solve more than half the diagnostic problem, for a simple investigative technique, the urethrocystogram, will supply the needed additional information. This should be done as early as possible in the course of initial survey, preferably while the patient is still in the emergency room undergoing x-ray studies.

Under clean conditions a catheter is passed into the urethra and a 12.5 per cent solution of sodium iodide is allowed to run in. X-rays made during the act of filling may show the characteristic extravasical filling and superior displacement of the

bladder, or the classical tear-drop deformity of the bladder created by the enlarging lateral hematomata.

Treatment involves immediate surgical exposure suprapubically, removal of all extravasated blood and urine, control of hemorrhage and re-establishment of urethral continuity.

Hemostasis and approximation of the torn ends of the urethra are accomplished by the two catheter technique. A Foley urethral catheter is passed by an assistant to, and then through, the membranous urethra and grasped with a forceps from above. A second catheter is passed via the cystotomy through the vesical neck, and the ends are sutured temporarily together. The upper catheter is then pulled back into the bladder drawing the Foley catheter into the opened viscus. The Foley bag is then inflated and by gentle traction the prostatic and membranous urethral ends are approximated. This accomplishes hemostasis and permits a satisfactory union. Suprapubic cystotomy should be done and maintained along with the urethral splinting catheter for two weeks. Failure to accomplish union early in the course of injury will result in an impassible and impossible stricture.

Pelvic injury also commonly involves loss of vesical integrity either by spontaneous rupture—or more often, by laceration from a moving fragment of bone. The hemorrhage and extravasation which ensues are often silent for some time, but should be suspected in all cases where pelvic fracture is present, especially where hematuria is an initial complaint. There is no substitute for a urethrocystogram performed as soon as x-ray survey is permissible.

The physician may permit himself to be misled by assuming that a pelvic fracture could not produce injury because there is no displacement of bone. A cystogram may show the obvious extravasation on bladder filling and emphasize the fact that what is seen on preliminary x-ray may not have been the situation at the time of injury, for the fractured pubic ramus may quickly slip back into relative alignment. Displacement of bone may be readily apparent and suggest the possibility of vesical laceration, which can be proved by urethro-cystogram. Sometimes the laceration is more extensive and may involve injury at the dome or lateral walls of the bladder with intraperitoneal extravasation.

(Continued on Page 969)

# Development of the Well-adjusted Child

By Benjamin B. Stamell, M.D.  
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SO MUCH has been written in the past ten years concerning the emotionally disturbed child, or the child with a problem, that a consideration of the factors that go into making a psychologically healthy child is in order. Much tension has been aroused in otherwise fairly well-adjusted parents by the anxieties of individuals, both lay and medical, who are interested in developing mental health programs in their respective communities. While this is not the intent of their program, guilt feelings on the part of parents are inevitable.

It is, therefore, the purpose of this paper to provide a discussion of the essential ingredients that help toward making a normal social and emotional adjustment for the developing child.

Becoming an emotionally healthy adult is a process of gradual maturation. The ability to assume responsibilities that face every grown-up individual does not suddenly occur when voting age is achieved, but rather is a situation of slow adjustment to the conflicts and rebellions that begin at birth and continue through life. Much of the end result depends upon the ground work and preparation laid in infancy and early childhood. Thus the rôle of the parent becomes of prime importance.

What, then, is necessary to provide for the development of well-adjusted, reasonably efficient and happy children? What are the qualities and attitudes that parents must foster in order to provide for an atmosphere in which children may flourish? What must they know about their children to provide them with this wholesome environment?

Basically, every child needs the affection of both its parents. The infant definitely needs the tender care of the mother, and a sense that father stands with her in providing emotional support. The comforting bodily contacts of the nursing infant with the mother, her prompt response to satisfy his needs and wants, and later the loving solicitude of both parents help give the child a feeling of security and well-being.

It may be said that the first step in the healthy

emotional development of the child is the capacity of the parents to give love, and in return that the child himself senses this love. During this early period, the child is completely dependent on them for his safety and comfort, and he should be aware that his parents are available in time of need. Therefore, if his dependency upon them is satisfactorily fulfilled, he will be comfortable and friendly; if it is not adequately met, he becomes tense and anxious. Parental affection is then the foundation upon which the child's feeling of security in life is built.

The emotional tie which is established with his parents in childhood greatly determines the individual's relationship with people in later life. It is from experiencing sympathy, understanding, patience, fairness, and encouragement of a wise parental love that the child is given a foundation for his later social attitudes. When the parent-child relationship is sound and wholesome, mistakes in the child's management are not likely to result in any serious or permanent harm to him.

Parents must provide an assurance of the stability of the home, for the child needs the protection of a firmly rooted environment. He needs confidence in their judgment. He should know that they will not make demands on him which he cannot meet. He must feel that they want him, and love him whatever his faults or shortcomings. His home must be a dependable refuge where he can return after his excursions into the outside world. There he can find understanding and counsel, and above all, emotional support, so that he can go forth again confidently to look for further experiences.

When a child learns by day-to-day contact with his parents that adults are tolerant and accepting people, even though at times they impose some restrictions, he will turn to new contacts with other adults and other children with a confidence that could only be the result of earlier experience. If a child is convinced that his parents are friendly and reliable people, then he himself inevitably adopts their attitudes. The child who feels reasonably secure in his parents faces his problems

with straightforwardness and self confidence. He is curious. He displays a desire for new experiences, a striving for self-enrichment and a pleasure in accomplishment. To him, the world is intriguing and challenging.

Acceptance of the individuality of each child is another basic need. Comparisons of one child with another is a common experience, and when a parent cannot accept the limitations of his offspring, problems frequently result. It is quite natural for them to want to create a child of whom they can be proud. But they must not apply too strict standards in the training of the child. How much better it is for children, when parents accept them as they really are, correctly evaluate their assets and liabilities, devise opportunities for them to make the most of what they have, allow them to develop at their own rate, and let them participate as well as they are able in the plans for their own activities and their own futures.

Parents can give children feelings of self respect and self esteem. They strive actively for these feelings. Confidence is built up within children by two types of experience: (1) the satisfaction which comes from achievement, and (2) the pleasure which results from the recognition of these achievements. Children must learn to sense their own worth. Anything which tends to make them feel unworthy or inferior is likely to evoke promptly some kind of defensive reaction. If children are unsure of themselves as persons in their own right, they may withdraw from social relationship in order to maintain their own sense of security by avoiding the hazards of group participation.

Recognition and approval for desirable behavior by parents have a great constructive value in child training. The attitudes which adults display toward a child's efforts are the chief means by which he can evaluate his own capacity and ability. It also determines the degree of satisfaction which he experiences in adopting a more adult type of behavior. When parents display interest in the child's activities and pleasure in his accomplishments, even routine tasks which he would otherwise consider as drudgery become not only tolerable but a matter of pride. Foundations for the later feelings of responsibility are thus laid.

A goal for parental management, then, is for each child to become an adult who can live happily and effectively in a competitive world. To accomplish this, the child must be nurtured and

protected until he is capable of handling situations for himself. Protection, of course, can be overdone or unduly prolonged, and the overly protected child may reach adult life unprepared to face the uncertainties and hazards which all adults must accept.

Properly timed, a feeling of insecurity may be character building. The value of such insecurity, however, depends on proper dosage; too much may defeat the purpose and result in unhappiness, and possible breakdown, and leave the child to enter adult life without confidence and faith in himself.

Parents must recognize a child's need for increasing independence. The infant, of course, is totally dependent upon his parents. However, every parent must realize that the day will come when their helpless child must become an emotionally mature adult who can stand on his own feet and win for himself a place in the professional, economic, and social world.

The ability to assume this responsibility is not a sudden acquisition. Rather, it is the result of a process of growth, training and experience throughout childhood. In late infancy, the need for independence becomes evident when the child discovers that he has a will of his own. He then enjoys exercising it by making his own decisions, participating in plans for himself, and resisting plans which are imposed upon him.

Parents certainly may impose demands upon their children but at the same time be generous in allowing them to make less important decisions. Most children accept reasonable restrictions provided they have the repeated reassuring experience of having their own needs considered when major decisions are not at stake. However, it is important that children not be forced to assume responsibilities until they have the capacity to do so.

Children are as aware as adults that they do not have the ability to judge values in an adult world. They become frightened and confused if the occasion arises where they are required to form judgments in matters beyond their abilities, but they gain a sense of confidence if they can be free to make decisions in matters in their own sphere of action.

Proper credit for adaptability is not often given to children by their parents. The responsibilities the growing boy or girl assumes are generally taken for granted. If the demands made of them are excessive they become, if not problem chil-

dren, then at least children with problems. They react vigorously to unreasonable demands by becoming irritable, defiant, and tearful. There then develops antagonisms and hostilities which could have well been avoided by understanding and patience.

In the home, the child needs a pattern within which he can organize his developing powers and capacities. Harmonious and constructive home life is hardly possible without some authority and order. When there is no authority in the home, or when authority is divided or inconsistent, chaos in home living results. The child becomes confused, feels insecure, and may acquire disrespect for all authority. This attitude may later interfere with his school and community adjustment. Children who have not learned the meaning of authority in the home frequently have great trouble in school.

Authority alone, however, is not enough to keep order. Authority may be ineffective and harmful if it is not understanding, reasonable and just. Without a background of affection, trust and mutual respect, authority deteriorates into pure tyranny. In the home, then, the child needs to learn that certain things are not done.

In every home, there are times and situations when parental firmness is necessary to limit behavior. Most parents realize that it is natural for children to test out the limitations in every new situation. Children need to know what acts will be permitted and what will happen if they do what is forbidden. It is, therefore, necessary for parents to determine where they must draw a line

for each individual child. Once having taken a stand, they hold firm and allow the child to learn by unpleasant experience that he has crossed that line. Thus, in these lessons of daily living, the child learns to bring his desires and aspirations into harmony with his family and the larger community.

### Summary

The mature individual represents an accumulation of many experiences. Stresses and strains from which he had been protected as a child have slowly brought increasing pressure upon him as he ages. The manner in which his parents handled these conflicts, and their reactions to them, largely determine his basic personality. If they have given him strength and confidence, he will resolve his problems in a satisfactory manner; if they have not given him these qualities, he may resort to many neurotic artifices during his lifetime.

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## ACCIDENT PRONENESS

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# Changing Flora in This Antibiotic Age

By Grayson Carroll, M.D.

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IN 1896, a gentleman described the colon bacillus and ascribed to it the cause of all urinary infections. This became so commonly accepted that the organism was given his name. For some forty years, urinary infections and *Escherichia coli* were synonymous. This error was not an important one clinically, so long as we had only urotropin as a drug to combat it.

In 1940, the treatment of urinary infection was greatly stimulated by the introduction of the sulfonamides, chemotherapeutic agent.

The thought concerning urinary infection was revolutionized, however, with the introduction of the antibiotics. Although some infections were dramatically cured, others were not, and it soon became apparent that no one antibiotic was effective for all types, or even all strains, of the organism found in the urinary tract.

A certain pattern began to form; first, that penicillin inhibited the coccal infections and streptomycin the bacillary infections, so it became necessary to know which was present in order to apply the proper drug. When streptomycin began to lose its potency, other antibiotics were discovered.

## The Tetracyclines

The tetracyclines\* as a group were found to be effective against the (1) *Escherichia coli*, (2) *Aerobacter aerogenes*, (3) *Paracolon*, (4) *Alcaligenes*, but totally ineffective against (1) the *Proteus*, (2) the *Pseudomonas*, and (3) the *Streptococcus fecalis* (*Enterococcus*).

Chloramphenicol (chloromycetin) was found to be most effective against the *Proteus*, but on the other hand not good in *Aerogenes* and *Paracolon*.

This selectivity made it necessary to revise our thought about most urinary infections being caused by *Escherichia coli* only. About nine organisms are commonly encountered in urinary infections.

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\*Tetracycline (Achromycin), Chlortetracycline (Aureomycin), Oxytetracycline (Terramycin).

We now realize that we are faced with the treatment of an organism and not so much a disease.

Another law began to work in this antibiotic age to prolong and make more difficult the battle between the complex organism (man) and the simple organism; that is, "the ability of an organism to adapt itself to its environment." Even in those instances where the organisms were killed, the more resistant type has taken its place.

We now have a preponderance of resistant staphylococci, and an increase in the frequency of the resistant bacilli; namely, the *Proteus* and *Pseudomonas*. Therefore, I shall confine my remarks to these three organisms. Each has certain behavior patterns whereby the clinician can ofttime recognize the organism he is combatting before any culture report is available.

## The Micrococcus

Forty per cent of acute pyelonephritis, especially in children, is caused by the staphylococcus. It is usually blood-borne and predominantly from respiratory infections. The acute unilateral pain and tenderness over the kidney with chills and fever, with or without pus in the urine, can be treated as a staphylococcus infection involving the cortical portion of the kidney.

If the same clinical picture is present, but the psoas shadow is obliterated on the KUB x-ray, a perinephritic abscess of staphylococcus origin may be suspected, since 90 per cent of perirenal abscesses are due to the staphylococcus. Skin infections, boils, and respiratory infections often precede perinephritic abscesses.

A persistent alkaline urine with infection which does not become acid by ammonium chloride medication and acid diet is either a staphylococcus infection or a *proteus*. A simple microscopic observation of the stained or unstained smear will distinguish between a coccus and bacillus. Treatment can be instituted against one or the other immediately before the cultural differentiation is

available. Stones with infections, encrustations of the bladder, or indwelling catheters are usually the proteus or the staphylococcus.

Fifty per cent of the staphylococci split urea in the urine to form alkaline urine and 100 per cent of proteus bacilli do the same. Rarely does the *Aerobacter aerogenes*, *Paracolon*, *E. coli* or streptococci do so.

Since respiratory infections are more common in the winter, one may expect to encounter coccal infections in the winter more often.

#### ***Streptococcus Fecalis* (enterococcus)**

The *Streptococcus hemolyticus* and *Streptococcus fecalis* are found in the urinary tract. May L. Porch examined 100 strains of streptococcus isolated from urine in children and found 70 were *Streptococcus fecalis*. This organism comes from the intestinal tract and not from the respiratory infections. It is exceedingly more difficult to treat, resisting most of the antibiotics and chemotherapeutic agents, and most successfully treated with mandelamine, 2.5 gm. tablets four times a day.

The *Streptococcus hemolyticus* coming usually from a sore throat is best treated with Ilotycin, 2 tablets four times a day, probably combined with streptomycin, 1 gm. injected intramuscularly every other day.

#### **Treatment of the Coccal Urinary Infections Considering the Changing Flora**

Ninety-six per cent of gonococcal infections were killed with the sulfonamides when first introduced. Only 16 per cent were controlled by the sulfa drug after two years' use of it. To date, penicillin is 96 per cent effective in gonococcal infections. Penicillin-resistant gonococci are rarely seen. Ninety-six per cent of staphylococcal infections were controlled by penicillin when first introduced, but now only 6 per cent are inhibited in those encountered in St. John's Hospital in St. Louis, and only 26 per cent in the Massachusetts General Hospital in Boston. Reports from other sources coincide with these figures.

The staphylococci which are capable of developing a penicillinase have survived. According to a survey made by K. Riley, two-thirds of the population has had penicillin therapy. This widespread use has decreased its effectiveness, especially in medical centers.

Because of this high percentage of resistant

organisms and the side reactions, many of which are very serious, penicillin should be given only in selected patients and not prophylactically or routinely any more.

Erythromycin or terramycin should be the drug of choice, although in areas where these have been used for three or four months, cocci resistant to them are developing.

The administration of streptomycin with erythromycin apparently helps prevent the development of resistant strains, according to Mantel.

Many new antibiotics were reported at the annual meeting on antibiotics in Washington, D. C., but none of these will kill the penicillin-erythromycin-resistant cocci.

#### ***Proteus***

The proteus may be suspected in any persistent urinary infection which fails to respond to tetracycline therapy or has a persistent alkaline urine.

The clogging up of indwelling catheters from "sandy" urine in these catheters is due to the proteus. Recurrent calcium stones are the result of proteus infection or staphylococcus also.

#### **Treatment for Proteus Infections**

Chloromycetin, gantrisin, and furadantin are the drugs to use when proteus is suspected. We are all familiar with the action of gantrisin and chloromycetin, but since furadantin is a newer drug, a few remarks may be made about it. We made a critical study of furadantin; it is nontoxic in required doses; it is excreted in high concentration in the urine. Our blood level determinations indicate that, though low, they are adequate to be clinically worthwhile. An initial dose of 200 mg. followed by 100 mg. four times daily, giving a booster double dose from time to time is recommended. It is the drug of choice, if tolerated, with patients with indwelling catheters, neurogenic bladders, cystoceles, et cetera. With persistent encrustations, Suby's solution should be used as a continuous or intermittent drainage.

#### ***The Pseudomonas***

This is the most resistant bacillus we have and most of the strains are not inhibited by any of our drugs. Of eighty pseudomonas organisms isolated, only five were sensitive to terramycin and only two sensitive to streptomycin. Yet the combination of streptomycin and terramycin controlled clinically sixty-seven out of eighty (84 per cent).

(Turn to Page 959)

### Clinical

For practical purposes, I think of infections as (1) acute, (2) persistent and (3) recurrent.

The *acute* infection may be treated expectantly; that is, with any drug of preference and a high percentage of the patients will be relieved without any further investigation.

The *persistent* infections are those that continue despite the administration of the drug. This indicates that the drug chosen would not inhibit the infecting organism, thus calling for the identification of the infecting organism.

The *recurrent* infection is the type that clears up under antibiotic medication indicating that the drug used inhibited the micro-organism present, however, after a period, the patient returns with a recurrence of the infection.

This means that although one is using the right drug, there is still a pathological lesion which brought about the recurrence. Obviously, a careful investigation must be now undertaken which includes many maneuvers, including a complete cystoscopic examination with x-rays.

The most common cause of recurrent infection is obstruction somewhere in the urinary tract, retarding the flow of urine and giving bacteria ample time to multiply. When these pathological lesions are discovered, they should be thoroughly treated to prevent the destruction ultimately of such a vital organ as the kidney.

### Urethritis in Children

The most common cause of urinary infection in children, especially female, is urethritis, and the most common source is a complicating vaginitis. A reddened area about the vagina and urethral meatus, with a thin watery discharge, is seen. Although the organism can be many different types, the proteus or pseudomonas from the fecal contamination is the most common. The treatment is dilations of the urethra in these small girls with a No. 10 sound, gradually dilating

to a No. 20. Furadantin suppositories, broken in half, should be inserted daily, if possible, in the urethra and also in the vagina. Local antibiotic ointments oftentimes cause increased irritation.

The resistant type of urethrovaginitis is often controlled by a suppository of 1/10 mg. of diethylstilbestrol inserted at bedtime by the mother, every other day for two weeks. The alkaline nature of the vagina encourages growth of organisms, and the stilbestrol changes the pH from 7.8 to 5.5. The dilation of the urethra in these chronic infections is tedious but important.

Urethritis in small boys needs a meatotomy which can be done in the office.

### Pyelitis of Pregnancy

Since this condition is caused by dilatation and atonic condition of the ureter, furadantin, which is secreted in large amounts and retained in urine, is very helpful, if tolerated.

The identification of the organism in so-called pyelitis of pregnancy is very important from the start, and in this type of infection the "hit-and-miss" therapy is to be condemned.

An indwelling urethral catheter is to be avoided, if possible, but oftentimes is the only method of drainage available and will avert disaster.

### Indwelling Catheters and Nephrostomy Tubes

If possible, the indwelling catheters should be hooked up to a closed circuit draining into a bottle at the side of the bed which has been boiled. The catheters should be changed every week or two. The medication should be continuous on small doses of either gantrisin or furadantin. We have patients who have taken these drugs for three months continuously without ill effects and prevented the growth of proteus which causes concretions.

539 N. Grand Blvd.  
St. Louis 3, Missouri

Bony metastases of renal cancer are most often osteolytic in character. \* \* \*

Bony metastases from prostatic cancer are osteoblastic in type. \* \* \*

The prognosis in most cases of renal cancer is determined by the steps taken by patient and physician when blood is first noticed in the urine.

The biopsy report, interpreted in terms of clinical findings, is the single, most decisive evidence upon which prognosis and therapy of cancer will be based. \* \* \*

Innumerable experiments and decades of clinical experience have shown that when biopsy is properly done there is little or no danger of spreading the disease.

# Human Relations in the Medical Profession

By Carl E. Schneider  
Detroit, Michigan

**Y**OU do me a great honor in inviting me here to speak before you. Frankly, I am filled with awe in the presence of so much learning and so much skill. My normal contact with the medical profession is on an individual basis of doctor and patient with an occasional consultant or two to prove the doctor's contention that I am a hypochondriac. I come here with the viewpoint of a man whose job is human relations and who has never looked on the doctor except through the eyes of a patient. It is this viewpoint that I hope to impart as I offer a few thoughts on the human relations aspect of the medical profession.

I realize that much is being done in this hospital and in others to make all staff members—doctors, nurses, attendants, everyone—aware of the importance of human relations. This is a never-ending job, to which the management of a hospital must devote its most careful attention. At the same time, it requires the whole-hearted support of the medical profession.

The reason is that so much in the hospital hinges on human relations. The patient is being treated in a place that is strange to him. He is perhaps frightened and he is ill. Merely an unkind word or action on the part of anyone connected with the hospital could produce an unfavorable reaction. Errors in human relations can harm a hospital's reputation and to some extent undermine confidence in the medical profession.

Since this is so, every member of the medical profession has a high stake in the hospital's good human relations. It is to his interest to promote them in any way he can, and there are certain things he can do in this direction. True, he does not determine the selection of people and their first training, both of which are important in obtaining proper attitudes with regard to conduct,

courtesy, duties and responsibilities. But these people's continuing, day-to-day guidance and approach to their duties depend to a large extent on the doctor.

In industry we have found that the attitude of management—whether displayed by a foreman, department head or top executive—pretty much sets the attitude of all the workers. As we are considerate and courteous, so are they. As we subject ourselves to discipline and accept our responsibilities, so do they. If by our friendly recognition of their work we make them feel that they are members of a team, they take greater pride in what they do—and do it better.

I don't mean by this that there is no discipline. Discipline is essential to any well-run business or institution. But it does not rule out a friendly atmosphere. Discipline to me means respect, acceptance of responsibility, proper conduct, courtesy, integrity and pride. I find nothing repugnant in these attributes. Proper discipline develops a strong and efficient team capable of meeting any emergency. It does not apply only to certain members of the staff; it must permeate the entire organization. It is a necessary ingredient in a good human relations atmosphere.

In any organization each member is entitled to and should feel a sense of accomplishment. He should have a feeling of belonging, of being a member of the team—a feeling of contributing to the over-all purpose of the institution. We all have a craving for recognition, no matter on what level we may work. And the leaders of the organization, in particular, have to be especially careful to give that recognition to each individual and to his work. More friendliness, more co-operation is required of them than of anyone else. When they do create a friendly atmosphere, every single worker can take pride in all the accomplishments of his organization and give his best to it.

Since the doctor does much of his work in the hospital, I have devoted some time to discussing before you some human relations factors you might wish to consider on the institutional level.

Presented before graduating senior residents, and medical staff, Harper Hospital, Detroit, Michigan, June 14, 1956.

Mr. Schneider is vice president and director of industrial relations, Burroughs Corporation. Also, he is president of the Board of the Rehabilitation Institute of Metropolitan Detroit, Inc.

However, that is only one side of the picture. The other side is the one that is exposed to people like me, the patients. Here I speak, not as a professional, but as a lay observer. And I am going to try with some trepidation to describe what we patients expect of our doctors.

The point that strikes us most forcibly about the medical profession is the dominating importance of personal responsibility. To laymen the doctor's responsibility appears so awesome that we are almost inclined to consider members of the medical profession as above the normal human frailties. More than most of us, they seem to have a never-ending obligation to study and learn better ways of helping their fellow men.

Such responsibility can only be met by hard work personally undertaken. There is a danger that confronts anyone who has had long institutional training. When he completes that training, the safeguards surrounding him are removed. His routine is changed; his supervision disappears. More play is given to his individual initiative, but conversely more initiative is required. Certain matters of more or less institutional responsibility now become, directly and totally, his personal responsibility. His obligation entails extra effort, the giving of his talents over and beyond the day-to-day requirements. It is up to him to foster within himself the constant urge and drive to improve in his profession.

It's true of every person who has a job that he must work to improve his ability. But the medical profession has the obligation to a unique degree. Most of us are dealing in products and services. If we fail to improve, our lack of effort would usually mean only dollars lost. The medical man, however, is dealing in the health and lives of other human beings. Hence he must be always ready to work at the top of his ability. And his ability is determined by the personal contribution he makes by way of study and work.

In industry we have for years been searching for training courses, tests and other educational devices to further the success of our people. Management development programs have been set up on a grand scale. Yet we always come back to one fact. If the man isn't interested enough in his own success to put forth extra effort and work, we are wasting time and money on these programs.

The doctor's reward for his effort must be satisfying in a way that we laymen can only guess at.

I am sure that the skilled surgeon who successfully performs a delicate operation deeply appreciates the extra hours and hard work that have made him expert in his profession. When the family physician struggles from his bed at 2 a.m., he is grumbling, grunting and grouchy. But when he returns two hours later, surely there must be a glow of accomplishment to reward him for relieving some one of severe pain or perhaps saving a life. That is success. It does not come suddenly, nor is it plucked from a tree. It is the meeting of two lines: one, opportunity; the other, preparations for responsibility. It is such extra giving that we patients have come to expect of doctors.

At the same time, we are inconsistent. While we expect the physician to be almost more than human in the performance of his duties, we still want him to be completely human. We want his complete personal interest in our case. We even want a certain amount of sympathy, or at least friendliness. We take it for granted that the doctor is trained to do his job correctly. But we want more; we want him to do the correct job with a human touch. He may be amused by our attitude or annoyed by it. He may think it is silly. But nevertheless—there it is. We ask that it be treated sympathetically. When we seek medical care, we are often frightened. We want the very best of care for those we love. We make difficult, perhaps unfair, demands because we are so aware of our own responsibilities. We are worried about ourselves and our families. Our emotions and our imaginations are involved as well as our flesh and blood and bones. The doctor cannot put a splint around our spirit, but he can by his friendliness give it a bracing tonic.

Man is not two people—one who lives, loves and walks free under the sun; the other who is wheeled into the hospital without emotion or the need of a friendly hand or cheerful word. The cadaver in medical school was a lifeless, soulless thing. The patient is a living human being with a soul, who looks hopefully to the doctor for more than his skill.

Right or wrong, that is our attitude and it is what doctors have to deal with. Have we always felt that it was considered sufficiently? I am afraid that the answer has to be, not always. On occasion I have heard complaints made by people who had been in a hospital for an operation. Their complaints went something like this: There was too much regimentation. There was an unfriendly

atmosphere. Although they were satisfied with the skill of the surgeon, they somehow felt that they were just another piece of bone and flesh rolled in to the operating room. The staff was too coldly professional. One man even commented that a doctor's internship should include his own submission to a major operation so that he could understand the patient's feelings. Whatever you may think of these complaints, they do indicate that these people experienced a lack of human relations atmosphere in the hospital.

Now I know that doctors cannot control the conduct of all the people connected with the hospital. However, I also know that doctors can greatly influence the whole staff by the example they set. Understandably, the doctor cannot allow himself to trip over his emotions by becoming overly sympathetic or too personal. Is there not, however, a medium position between chill competence and over emotional sympathy?

I bring up this point because for some reason some professional men almost cease to be human beings when they become a member of a profession. We have the problem in management circles of industry. Some have the feeling that professional men should be mentally and emotionally disciplined to the point that normal reactions and resentments are controlled; that, being professionals, they are not interested in recognition and need give none to others. Sometimes there creeps into professional groups a brusqueness of manner that chills the hearts of those with whom they deal. There develops an aloofness that is extremely difficult to penetrate or understand. Occasionally we meet the "two-hat man." Under one, he is the intelligent, cordial, friendly husband and father and respected member of the community. Under the other hat, he becomes the intelligent, successful, arctic cold professional.

Now, of course, it isn't true that the professional has no hunger for recognition, appreciation and understanding. But what is more to the point, other people are repelled and hurt by this frigid attitude. We, the patients, appreciate the doctor's skill and depend on it. We hope for more than just his skill to help us.

I have always been impressed by a code for living attributed to Stephen Grellet. He wrote: "I expect to pass through this world but once. Any good therefore that I can do, or any kindness that I can show any fellow creature, let me do it

now. Let me not defer or neglect it, for I shall not pass this way again."

The whole life of a doctor is a carrying out of the letter of that code. His fullest potential for success in healing will be attained in carrying out the spirit of it as well.

Beyond his sense of responsibility and his human warmth, there is another quality that we laymen expect of a doctor. We expect a sense of dedication. What a heart-warming tribute it is to the whole profession of medicine that we have come to expect it! In the course of his internship, the young medical man or woman may have run into situations which somewhat dull this sense of dedication. It may seem rather naive to mention it. And yet you men and women surely have it. You would not have undergone all the sacrifices of the past years if you did not. Let it come to the fore. Let your calm and determined choice of the healing profession be renewed in your hearts—and keep it there always. Greater or less skill in different doctors is understandable. Greater or less intelligence is characteristic of doctors as it is of all men. There can be no greater or lesser degree of dedication to the calling of medicine.

As you continue your profession, your sense of dedication will be sorely tried. You can count on that. You will meet whinning patients and dead-beats and a lack of ordinary gratitude. You will be busy with a hundred tasks of office administration that have little to do with healing. You will be tempted, perhaps, to lose sight of the fact that yours is a dedicated life.

I don't think that I am presumptuous when I say that I speak here with the voice of hundreds and thousands of people. And what we are all saying is: "Don't lose that sense of dedication. Keep it strong with you. We need it. We need to think that your life is devoted to protecting us and those we love. We trust you with our babies, our husbands and wives, our own lives. We desperately need the confidence that comes from putting our health in your dedicated hands. We know that you will never fail us."

And now may I congratulate you men and women who have successfully passed through your period of training and are now about to embark on a noble career. I wish you every success. You enjoy an advantage in your work peculiar, I believe, to your profession alone. For almost every

(Continued on Page 972)

# Symposium on Blood

## Wayne State University College of Medicine

Saturday, January 21, 1956

### FOREWORD

An annual Symposium on Blood is held at Wayne University College of Medicine each year on the third Saturday in January. It is a unique meeting of its kind which attempts to be as informal as possible and where outstanding work related to recent developments is discussed. Papers are presented by investigators from all parts of the nation and usually there are some from overseas. Emphasis is placed on material commonly referred to as fundamental research. In the evening after the symposium, many of the participants forgather at one of the famous local restaurants for dinner and getting acquainted.

### PROBLEMS IN MEGAKARYOCYTOPOIESIS

By JOHN W. REBUCK and RAYMOND W. MONTO  
*The Henry Ford Hospital, Detroit, Michigan*

The orderly delivery of platelets to the blood is dependent upon the integrity and normal functioning of the megakaryocytic series of cells in man. Normally the bulk of the megakaryocytes are found in the hematopoietic marrow. The youngest member of the megakaryocytic series is termed the megakaryoblast, which forms the promegakaryocyte, which in turn forms the megakaryocyte or platelet-forming cell. Ordinarily the megakaryoblast is derived from the myeloblast (hemacytoblast) or reticulum cell (mesenchymal cell). The cytoplasm of the megakaryocyte forms platelets either by breaking up of pseudopodial processes or by simultaneous disintegration of large portions of the entire cytoplasm. In pernicious anemia, thrombocytopenia is brought about by systemic disturbance of the megakaryocytes. Vitamin B<sub>12</sub> deficiency leads to failure of nuclear maturation, excess multinucleation, failure of granule formation, and results in poor platelet formation. In idiopathic thrombocytopenic purpura in contrast, thrombocytopenia is present in the face of usually increased numbers of megakaryocytes. In the latter disease, antibodies effect peripheral vacuolation of megakaryocytic cytoplasm, disappearance of granulation and retardation or cessation of platelet formation. Extensive histochemical studies reveal a striking correlation between findings in platelets and megakaryocytic cytoplasm. Heat stroke brings about an almost specific injury of megakaryocytes among the blood-forming cells.

This is the fifth annual Symposium on Blood held at Wayne State University College of Medicine.

AUGUST, 1956

### BIOCHEMICAL STUDIES ON LEUKOCYTES

By WILLIAM N. VALENTINE and JOHN S. LAWRENCE

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Human leukocytes possess a complex biochemical constitution with metabolic patterns and enzymatic activities, which can be expected to vary with individual leukocyte types in health and with the altered environment resulting from disease. It is therefore of importance to characterize the biochemical machinery of normal leukocytes and the altered patterns engendered by intrinsic disease of hemopoietic tissues and by disease basically involving other body tissues. While of necessity much of such characterization must initially be descriptive, it can be hoped that ultimately data obtained may be useful in diagnosis and as a clue to possible avenues for therapy.

Leukocytes of all types consume oxygen, utilize glucose via the Embden-Myerhoff and other cycles and produce lactic acid. Granulocytic leukocytes contain glycogen while mononuclear cells possess little or any. The enzyme beta-glucuronidase and free glucuronic acid are present, again this activity being low in cell populations composed primarily of blast cells or mononuclear cells. Leukocytes also contain, among other investigated constituents, free glutathione, transaminase, acid and alkaline phosphatases, esterase, lipase and in the case of the basophil histamine.

In studies involving leukocyte respiration it has been found that the addition of chloromycetin to fortified homogenate systems results in significant reduction in O<sub>2</sub> consumption, although comparable levels of penicillin, aureomycin, and terramycin fail to exhibit this effect. Atabrine is a powerful inhibitor of leukocyte respiration in such systems, and respiration is not appreciably restored by additions of hydrogen acceptors, such as methylene blue. Cyanide inhibits but does not eliminate respiratory activity, the inhibition being counteracted by methylene blue. *In vitro* experiments indicate that sustained, undiminished respiratory activity is preserved for some reason much better with cyanide and methylene blue than with methylene blue alone. Alkaline phosphatase of leukocytes has been extensively studied. This activity is uniquely low in chronic myelocytic leukemia, high in a variety of leukemoid reactions and in myeloproliferative syndromes morphologically re-

sembling chronic granulocytic leukemia, and elevated on a unit cell basis in a wide variety of disease states where increased pituitary-adrenal activity is expected. Substantial elevations also occur when ACTH is administered over a seventy-two-hour-period in large doses to individuals with intact adrenals, but not in the presence of Addison's disease or complete adrenalectomy. Steroids of the cortisone type also evoke this response in either presence or absence of adrenal glands, except that the low values in chronic granulocytic leukemia are unaffected by either ACTH or cortisone-like steroids, a fact suggesting a failure of end organ response but not adrenal insufficiency. Alkaline phosphatase is capable of splitting off phosphorus from a wide variety of phosphomonoesters of physiologic importance, including adenosine-5-phosphate. Explanation of the multiple functions of this enzyme in leukocytes, as in other tissues, awaits better understanding of its role in metabolism. It should not be construed, however, that increased adrenal activity in "stress" is necessarily the only mechanism capable of producing the unusual elevations in activity observed.

#### APLASTIC ANEMIA: NATURAL HISTORY AND INCIDENCE IN MODERN THERAPY

By JAMES A. WOLFF, HATTIE E. ALEXANDER, ALLYN B. LEY and FRANCES ROWE

Columbia University and Memorial Hospital, New York, New York

A careful review of the records of all cases of aplastic anemia meeting criteria for diagnosis established by the investigators has been made in fourteen large teaching hospitals in the Eastern United States. This study covered the period 1944-1954.

The clinical features and laboratory data of the disease have been analyzed. The duration, response to treatment and final outcome have also been evaluated. Special consideration has been given to the role of modern drugs, particularly antibiotics, as possible factors in the pathogenesis of the disease.

A total of 334 cases of aplastic anemia have been included in the study. Of these, sixteen met the criteria for diagnosis during the course of illness but were rediagnosed terminally or at post-mortem as leukemia or myelofibrosis. Of the total series, 66 per cent died, 7.7 per cent are still under treatment, 23 per cent were lost to follow-up, and 3.3 per cent recovered.

Therapy, including splenectomy, ACTH, and cortisone, failed to influence the course of illness. In over half the patients no antibiotic was administered in the period prior to the onset of symptoms. A number of different antibiotic agents had been administered in the remaining cases. In the year 1952 an increased incidence of aplastic anemia occurred, primarily due to cases associated with chloramphenicol administration.

Because of other factors which might have influenced the incidence of cases at this time, and because of the relatively small number responsible for the increase, interpretation and statistical evaluation of this increase is not possible.

#### THE SLOW AND RAPID FREEZING OF BLOOD: THE MECHANISM OF CELL INJURY AND ITS PREVENTION

By HAROLD T. MERYMAN

Naval Medical Research Institute, Bethesda, Maryland, and Yale University, New Haven, Connecticut

One of the most intriguing and important phenomena in the freezing of a cellular biologic medium is the formation, at slow rates of freezing, of exclusively extracellular ice crystals. Such crystals generally do not do mechanical damage, but merely withdraw water from both intra- and extra-cellular spaces, causing a passive collapse of the cell. Cell injury under such circumstances is not mechanical, but chemical, and is due to dehydration from the freezing out of water and the resultant high concentration of electrolytes. The current use of glycerine to prevent freezing injury is based upon its ability to pass freely through cell membranes, to bind water and to prevent it from crystallizing, thus reducing the ultimate electrolyte concentration to an acceptable limit.

As the rate of freezing is accelerated ice crystals begin to be formed within the cell, and mechanical as well as chemical injury becomes possible. Intra-cellular crystallization obviously can be tolerated only if the crystals are reduced to a sufficiently small size to be nontraumatic. The aim of any rapid freezing technique must be, by an appropriate choice of specimen size and geometry and of cooling medium, to attain an extreme rate of freezing through efficient heat exchange. Such a rapidly frozen microcrystalline preparation, however, is metastable since, unless the temperature is sufficiently low, crystal size may continue to increase in the solid state with larger crystals growing at the expense of small. In addition, electrolyte concentration remains as potentially lethal a factor as it was following slow freezing. Both crystal growth and denaturation by electrolytes are temperature dependent and for this reason storage temperatures must be low and thawing extremely rapid.

By recognizing and applying these principles to the freezing of whole blood, it has been shown that sufficiently rapid freezing can be attained if the blood is dispersed into extremely small droplets by spraying through a fine plastic capillary onto the surface of liquid nitrogen. Such frozen blood, when reconstituted by sprinkling the frozen droplets into warm saline or plasma, appears morphologically intact with respect to all the formed elements. Two human transfusions and several rabbit transfusions of whole blood containing

chromium 51 tagged erythrocytes demonstrate that normal survival *in vivo* is possible following this procedure. Casual examination finds the platelets somewhat reduced in number but morphologically intact. *In vivo* studies of platelet and leukocytes are in process with results not yet available. A battery of tests showed no demonstrable alteration in the clotting mechanism of the plasma.

Blood prepared in conventional ACD medium and subjected to freezing and thawing generally suffers about 15 per cent erythrocyte hemolysis. On the basis of the ability of strong hydrogen bonders to reduce crystallization velocity and thus decrease crystal size, either urea or additional glucose is added to the blood. Although there is some question regarding the rationale of this therapy, it has nevertheless proven successful, permitting the recovery of nearly 98 per cent of the erythrocytes.

Storage at temperatures higher than  $-50^{\circ}\text{C}$ . results in prompt destruction of the blood. At  $-60^{\circ}\text{C}$ . there is an accumulation of hemolysis during storage at the rate of 1 per cent per week. Preservation becomes increasingly good with lowered temperature. With storage in liquid nitrogen, actually the cheapest and easiest form of refrigeration, the period of preservation can be considered as essentially infinite.

#### THE ROLE OF PLASMA THROMBOPLASTIN COMPONENT (PTC) IN BLOOD COAGULATION

By THEODORE H. SPAET

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Montefiore Hospital, New York, New York

During a study on the inactivation of blood thromboplastin, it was found that a plasma protein in crude fraction V of Cohn was responsible for thromboplastin inactivation. Since this protein exhibited many properties of antithrombin, the effect of thrombin in restoring thromboplastin activity was studied. Trace amounts of thrombin elicited considerable thromboplastin activity in mixtures containing inactivated blood thromboplastin. These data led to the discovery that thrombin was an effective substitute for plasma thromboplastin component (PTC) in the thromboplastin generation test. Moreover, thrombin corrected the impaired prothrombin consumption of PTC-deficient blood. The possibility of contamination of the thrombin with PTC was excluded by showing that thrombin inactivated in barium sulfate-adsorbed plasma had no effect on PTC-deficient blood, and that thrombin inactivated in barium sulfate-adsorbed serum was inert in the thromboplastin generation test. Nonspecific thromboplastic effects of thrombin were ruled out by the demonstration that thrombin failed to improve prothrombin consumption in hemophilic and thrombocytopenic bloods. Of interest is the

finding that "PTC" activity was elicited in PTC-deficient plasma and serum by incubation with thrombin, although these mixtures failed to clot purified fibrinogen.

The hypothesis is suggested that PTC is a derivative of prothrombin which serves as a ready source of thrombin to initiate blood coagulation. It is further suggested that PTC deficiency consists of a failure to convert prothrombin into this derivative.

#### THE CONVERSION OF PROTHROMBIN TO AUTOPROTHROMBIN II (PLATELET COFACTOR II) AND ITS RELATION TO THE BLOOD CLOTTING MECHANISMS

By SHIRLEY A. JOHNSON and WALTER H. SEEGER  
Wayne University, Detroit, Michigan

Under certain restricted conditions purified thrombin can be added to purified prothrombin and the latter transforms to a derivative called autoprothrombin II. Except in 25 per cent sodium citrate solution, the derivative has not been converted to thrombin. It functions as a co-factor with purified platelet factor 3 in the conversion of prothrombin to thrombin. Serum from healthy persons and in hemophilia A contains autoprothrombin II activity that can be adsorbed on  $\text{BaCO}_3$ . Autoprothrombin II, prepared in the laboratory, can be added to the two types of adsorbed serum and the autoprothrombin II activity is restored to the serum. Serum from a PTA patient, and a patient receiving Dicumarol® was found to contain very little autoprothrombin II activity. By adding an appropriate quantity of autoprothrombin II, prepared in the laboratory, the autoprothrombin II activity of the PTC serum was not completely restored whereas it was with the other two serum samples.

#### A NEW SERUM FACTOR (FACTOR X)

By F. DUCKERT, P. FLUCKIGER and F. KOLLER  
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The results obtained with normal and pathologic sera in a modified thromboplastin generation test cannot be explained by interactions of only factor VII and factor IX (Christmas factor or PTC). The existence of a new clotting factor, factor X, must be postulated and it is also possible to prove that factor VII does not act in the formation of blood thromboplastin.

After treatment with a Dicumarol® derivative, Marcoumar, it is possible to observe in serum three phenomena: (a) factor VII activity decreases rapidly, (b) the activity in the thromboplastin generation test more slowly, and (c) the capacity of this serum to normalize factor IX deficient serum is not diminished. After vitamin  $\text{K}_1$  administration, however, factor VII returns to the normal level without parallel normalization in the thromboplastin generation test.

This experiment alone excludes an important participation of factor VII in the thromboplastin formation and gives place to a new clotting factor, factor X. It is possible to confirm this hypothesis by carrying out experiments with purified factors and pathologic sera in different combination in pairs.

Partial purification of factor IX and X can be achieved by adsorption on  $\text{BaSO}_4$  and elution with citrate solution.

Factor X reacts during treatment with dicumarol derivatives or vitamin  $\text{K}_1$  more slowly than factor VII; it is deficient in the sera of patients suffering from hepatitis and cirrhosis; it is normal in factor IX (Christmas or PTC) deficiency.

### ANAPHYLAXIS, RADIATION AND HEPARIN

By FRANK C. MONKHOUSE

University of Toronto, Toronto, Ontario

The arrival of the Atomic Age ushered in by the bombing of Hiroshima and Nagasaki revived interest in the cause of the hemorrhagic syndrome associated with severe irradiation. In large-scale experiments Allen and his associates (J. Exper. Med., 87:71, 1948) were the first to suggest that the prolonged clotting time in irradiated dogs was due to the release of heparin. While they were able to extract an anticoagulant material from the blood of a few animals early in their experiments, they were not able to repeat their results and concluded (Allen, J. G., Blood Clotting and Allied Problems. Fifth Macy Conference, 1952, p. 231) that the anticoagulant may have been released as a result of an anaphylactic reaction following repeated transfusions. If such were the case, it suggested that irradiated animals might be more prone to anaphylaxis than normal animals. This consideration, plus the suggestion by Cronkite (In C. F. Behrens' *Atomic Medicine*. New York: Wilson, 1949 p. 146) that animals might possibly become sensitized to their own denatured proteins, led us to study the heparin output in anaphylactic shock superimposed on the effects of irradiation. For this purpose animals were sensitized to horse serum and subsequently shocked at varying intervals after body irradiation. Since it has been shown that heparins of different species exhibit markedly different anticoagulant potencies (Jaques, L. B., and Charles, A. F. Quart. J. Pharm. & Pharmacol., 16:1, 1941), we used rats, rabbits, guinea pigs and dogs. Our results indicate that in sensitized rabbits and dogs irradiation increases the degree of reaction to a given amount of antigen, provided this amount would cause a submaximal response in similar nonirradiated animals. While such a phenomenon might explain the presence of an anticoagulant reported to occur in irradiated dogs, it is difficult to see how it could be of any importance in the other species of this study. Rats

are difficult to shock and the amount of heparin released by guinea-pigs and rabbits, even in fatal reactions, is very small. Apart from anaphylaxis, we have been unable to find heparin in the blood of rats, guinea pigs, rabbits or dogs at any time after these animals have been irradiated, even when signs of hemorrhage have been found after death. It is unlikely, therefore, that heparin is an important contributing factor to the hemorrhagic manifestations.

The importance of thrombocytopenia has been emphasized (Penich, G. D., E. P. Cronkite, I. D. Godwin and K. M. Brinkhous. Proc. Soc. Exper. Biol. & Med., 78:732, 1951). Their dogs were subjected to severe irradiation and showed definite prolongation of clotting time. We found that if dogs were exposed to small constant amounts of radiation, the animals could be maintained at a very low platelet level (below 10,000/cmm.) for two to three weeks without gross evidence of hemorrhage. Hemorrhage into the lymph nodes may possibly have occurred. These experiments suggest, however, that something besides platelet depletion is required to initiate bleeding when such long periods of thrombocytopenia can occur without it. In this regard the recent work of Savitsky and Sherry (Proc. Soc. Exper. Biol. Med., 85:587, 1954, and Savitsky, J. P., Blood 10:52, 1955) is very interesting.

### IN VIVO AND IN VITRO STUDIES ON THE ACTIVATION OF THE FIBRINOLYTIC ENZYME IN HUMAN PLASMA BY STREPTOKINASE

By SOL SHERRY

Jewish Hospital of St. Louis, and Washington University, St. Louis, Missouri

It is well established that mammalian plasma contains a proteolytic and fibrinolytic enzyme precursor termed profibrinolysin or plasminogen. Upon activation, the proenzyme is converted to the active enzyme termed fibrinolysin or plasmin. At present, streptokinase (SK), an extracellular secretory product of hemolytic streptococci, is the most potent activator for human profibrinolysin.

The mechanism of activation of profibrinolysin by SK appears to be a two-step process. SK first combines with a plasma factor in stoichiometric fashion to form an activator, which then kinetically converts profibrinolysin to fibrinolysin. There is suggestive evidence that the plasma factor with which SK combines to form the profibrinolysin activator may actually be human profibrinolysin or fibrinolysin.

In animals, controlled fibrinolysis, capable of dissolving preformed occlusive arterial thrombi, as well as fibrinous exudates at sites of inflammation, has been accomplished by intravenous injections of streptokinase.

An exploration has also been undertaken of the therapeutic potentialities of intravenously admin-

istered streptokinase in man. During the infusion of SK, activation of profibrinolysin and suppression of antifibrinolysin activity occurs, and is associated with intense fibrinolytic activity. With the cessation of the SK infusion, the rate of profibrinolysin activation rapidly decreases and the antifibrinolysin activity rapidly returns to normal. These latter changes are associated with a rapid reduction in fibrinolytic activity. As suspected from *in vitro* observations fibrinogenolytic activity proceeds at a much slower rate than fibrinolytic activity. Although no serious toxic manifestations have been observed, "pyrogenic" reactions to the presently available SK preparations have hampered the *in vivo* study in man.

#### PURIFICATION OF TRYPSIN-ACTIVATED BOVINE FIBRINOLYSIN

By EDWIN T. MERTZ and ARTHUR DALBY  
*Purdue University, Lafayette, Indiana*

A method for the preparation of trypsin-activated bovine fibrinolysin has been published (Jackson, H. D. and Mertz, E. T.: *Proc. Soc. Exper. Biol. & Med.*, 86:827, 1954) and some of the properties of such preparations described (Ronwin, E. and Mertz, E. T.: *Federation Proc.* 14: 271, 1955).

Further studies on trypsin-activated products and fractions obtained therefrom have been carried out using an improved method of assay. The new procedure makes use of the conventional Warburg manometric technique. When fibrinolysin splits the ester group of *p*-toluene sulfonyl-L-arginine methyl ester (TAME), the amount of carbon dioxide released from bicarbonate buffer is measured. The advantages of this method, when compared with the fibrinolysis and null point titration methods, are speed, reproducibility, and the fact that only microgram quantities of enzyme preparations are required.

Current developments on the purification of bovine fibrinolysin in this laboratory were discussed.

#### INHIBITION OF THROMBIN FORMATION BY SULFHYDRYL OXIDIZING AGENTS: ATTEMPTS TO ELUCIDATE ITS MECHANISM

By J. L. KOPPEL, D. A. MUELLER and J. H. OLWIN  
*Presbyterian Hospital, Chicago, Illinois*

The formation of thrombin is inhibited by oxidized glutathione and other sulfhydryl-oxidizing substances. This effect can be observed with purified prothrombin and with prothrombin as present in human and dog plasma. Evidence has been obtained to indicate that prothrombin itself does not play a direct part in the observed inhibitions. With all inhibitors tested, the degree of inhibition obtained is considerably higher with dog

plasma than with human plasma. Increasing concentrations of oxidized glutathione in the presence of dog plasma result in inhibitions of thrombin formation approximating those found with human plasma. This suggests that a prothrombin conversion accelerator may be involved which is present in higher concentrations in dog plasma than in human plasma. Experiments have been carried out with purified clotting factors and various types of serum preparations in order to determine the point of these inhibitors. The inhibitions can be prevented by normal human serum or autoprothrombin I. The results of these and other findings suggest a possible interaction of the inhibitors with one of the constituents of the system concerned with the formation of this prothrombin derivative. They also suggest that free sulfhydryl are essential for the activity of this constituent. Possible implications of these findings are discussed.

#### SOME STRUCTURAL ASPECTS OF THE PROTHROMBIN-THROMBIN SYSTEM

By KENT D. MILLER and HELEN VAN VUNAKIS  
*New York State Department of Health, Albany, New York*

Di-isopropylfluorophosphate (DFP) was found to have no effect upon purified prothrombin. Thrombin derived from this prothrombin was rapidly inhibited by very low concentrations of DFP. Quantitatively, both the clotting and esterase activities of thrombin are affected to the same extent by a given amount of DFP, suggesting that a common center may be functional in both enzymic processes. The reaction between the enzyme and DFP is accompanied by an uptake of phosphorus, a point which is of particular importance in establishing a means of labeling the active region of the molecule(s). Neither heat-denatured thrombin nor prothrombin bound phosphorus when exposed to DFP.

The inhibition of thrombin by DFP occurs whether the enzyme is derived from purified prothrombin by bio-activation or by autocatalytic activation in 25 per cent sodium citrate solution.

The over-all reaction by which tissue thromboplastin, serum accelerators, and ionic calcium activate prothrombin is unaffected by DFP. However, the activation of prothrombin in 25 per cent sodium citrate solution is completely blocked in the presence of DFP, establishing further the strict necessity for the presence of active thrombin in this activation process. Prothrombin activity in 25 per cent citrate plus DFP solution is completely stable, and no dissociation phase, that is, formation of TCA-soluble products, was observed.

No N-terminal or C-terminal amino acids have yet been found in purified prothrombin preparations by the dinitrophenyl technique or by carboxypeptidase digestion. Further studies, however, are necessary to confirm the absence of those ter-

terminal amino acids either labile or resistant to the methods used thus far. Should further tests fail to reveal terminal amino acids, the question arises whether prothrombin is actually a cyclic protein or whether sugar residues are linked to the terminal end(s) of the protein.

## STUDIES ON THROMBIN FORMATION

By H. JENSEN

*Army Medical Research Laboratory, Fort Knox, Kentucky.*

In the coagulation of blood the conversion of prothrombin to thrombin is preceded by the formation of a prothrombin converting factor. The present investigation concerns itself with the intermediate reaction involving the formation of a prothrombin activator prior to the conversion of prothrombin to thrombin.

Preincubation of a  $\text{BaSO}_4$ -eluate from rabbit serum with platelets and  $\text{CaCl}_2$  in the presence of plasma accelerator globulin or of antihemophilic factor or of both plasma accelerator globulin and antihemophilic factor, before addition of the "prothrombin" source to the reaction mixture, resulted in a marked enhancement in the prothrombin conversion as compared with a one-stage thrombin formation procedure. Replacement of platelets or  $\text{CaCl}_2$  with buffer in the reaction mixture did not yield any prothrombin converting activity. The greater velocity of thrombin formation in the two-stage procedure indicates that precursory interactions of certain factors had been initiated or completed during the preincubation.

Preincubation of either platelets, antihemophilic factor and  $\text{CaCl}_2$  or of platelets, plasma accelerator globulin and  $\text{CaCl}_2$  or of platelets, plasma accelerator globulin, antihemophilic factor and  $\text{CaCl}_2$ , before addition of the "prothrombin" source plus serum eluate to the preincubation mixture, resulted in approximately the same rates of thrombin elaboration as found in the one-stage thrombin formation procedure. These findings indicate that no interaction between the various factors had taken place during the preincubation period under these conditions. It appears from these observations that antihemophilic factor as well as plasma accelerator globulin did interact with platelets and calcium ions only in the presence of factor(s) in serum eluate yielding prothrombin converting activity.

## SOME EFFECTS OF PROTEOLYTIC ENZYME INHIBITORS ON BLOOD COAGULATION

By N. RAPHAEL SHULMAN

*Naval Medical Research Institute, Bethesda, Maryland*

A proteolytic inhibitor with anticoagulant activity, a protein with a molecular weight of approximately 17,000, was purified from normal human plasma and urine. The nature of its action

as an anticoagulant was studied and was compared with that of the soy bean trypsin inhibitor. The mechanism of inhibition of coagulation was found to be the same with both inhibitors.

The data obtained on thrombin yield and the time-course of thrombin formation by varying concentrations of the various reagents in mixtures, consisting of purified prothrombin, thromboplastin, serum accelerators of prothrombin conversion, proteolytic inhibitor, and  $\text{Ca}^{++}$ , led to the following conclusions. Inhibition of thrombin formation is not due to interaction between inhibitor and any of the materials present in the system before activation of prothrombin takes place or between inhibitor and thrombin. The degree of inhibition of thrombin formation is, however, related directly to the amount of prothrombin used and inversely to the rate of conversion of prothrombin into thrombin. A model reaction which fits all of the data necessitates postulating that a compound intermediate between prothrombin and thrombin exists and that the inhibitor acts on this intermediate product which is formed during the conversion of prothrombin to thrombin. The model is:

1. Prothrombin (P)  $\xrightarrow{k_1}$  Altered prothrombin ( $\text{P}^*$ )
2.  $\text{P}^* \xrightarrow{k_2}$  Thrombin (T)
3.  $\text{P}^* + \text{Inhibitor (I)} \xrightarrow{k_3} \text{P}^* \cdot \text{I}$   
 $k_1, k_2, k_3 = \text{rate constants}$

The arrows in the above reactions point in only one direction since it appears that all of the steps are irreversible under ordinary conditions required for prothrombin conversion. Reactions 2 and 3 occur simultaneously. The amount of  $\text{P}^* \cdot \text{I}$  formed is dependent on  $k_2$ , and  $k_2$  is dependent on conditions which are known to affect the rate of formation of thrombin from prothrombin, i.e., on the concentration of thromboplastin, accelerators,  $\text{Ca}^{++}$ , and on temperature. The greater  $k_2$ , the less  $\text{P}^* \cdot \text{I}$  formed. Once  $\text{P}^* \cdot \text{I}$  is formed, the bound  $\text{P}^*$  is not available for conversion into T. The factors which convert  $\text{P}^*$  into T do not compete with I for  $\text{P}^*$ , and  $\text{P}^* \cdot \text{I}$  under these conditions is not dissociable.  $\text{P}^* \cdot \text{I}$ , however, can be dissociated by trypsin because the dissociation constant of the inhibitor-trypsin complex is smaller than that of  $\text{P}^* \cdot \text{I}$ . When an amount of trypsin equimolar with respect to I is added to the inhibited reaction, units of thrombin recovered are equal to those obtained if no inhibitor is present.

The following formula, expression inhibition in terms of the various conditions which affect it, was devised by Dr. John Z. Hearon:

$$\text{Units inhibited} = \frac{\text{P}_0 \text{I}}{\frac{k_2}{k_3} + \text{I}}$$

$\text{P}_0 = \text{units prothrombin used}$   
 $\text{I} = \text{inhibitor concentration}$

Experiments using whole plasma indicate that P\* apparently always forms during normal coagulation. The naturally occurring anticoagulant proteolytic-inhibitor is estimated to be present in plasma in sufficient amount to act in the early stages of blood coagulation. The plasma inhibitor can be considered as a buffer in coagulation. It would be completely effective in preventing thrombin formation at the slow rates of P\* formation which might occur intravascularly as its effect would diminish and become insignificant with the increased rate of prothrombin conversion which occurs extravascularly. The inhibitor may be of importance in maintaining the fluid state of the blood.

### COMPARISON OF SOME PROPERTIES OF PLATELET AND TISSUE EXTRACTS

By EDMUND KLEIN and SIDNEY FARBER  
*Harvard University, Boston, Massachusetts.*

Lipid constituents of platelets, and other mam-

malian and avian tissues which contribute to the correction of the defective generation of thromboplastin in thrombocytopenic blood, have been obtained. Reference will be made to studies of John Garrett, at present associated with our group, and to the collaboration of Marian Rumley. Purified preparations were active at concentrations of one part per million. At high concentrations these preparations appeared to inhibit the generation of thromboplastin and the coagulation of fibrin by thrombin. During the course of purification, at least some of the inhibitory activity was removed. The purified preparation obtained from platelets resembled those from other tissues in their solubility characteristics and in their respective ultraviolet and infrared spectra.

The wide distribution of the activator suggested investigation of organisms without a circulatory system, and presumably, therefore, without a blood clotting mechanism. Active preparations have been obtained from yeast, which may imply that this activity is not necessarily related to blood coagulation.

### PREVENTION OF ACCIDENTAL TRAUMA

(Continued from Page 948)

with his environment in the past fifty years. This struggle, resulting in a remarkable degree of control, has been directed against the communicable diseases, using such means of control as sanitation, immunization and the newer antibiotics. Today, machines and toxic chemicals—thanks to our technologic progress—loom as greater threats to life than germs. The protection of the individual from

these and other causes of injury is a challenge worthy of the skills of modern medicine and public health. Accident prevention has the added value of being an ideal subject for the public relations program of the medical profession.

Accidental trauma, of all the leading causes of death, offers the most promise at the present time for further improvement in life expectancy.

### INJURIES TO THE GENITO-URINARY TRACT

(Continued from Page 953)

In all cases, any evidence of extravasation is an immediate indication for suprapubic exposure and repair of the injured viscus. The technique for correction of the transperitoneal defect consists of removal of all blood and urine by suction, followed by primary 2 layer suture of bladder wall and peritoneum. Suprapubic cystotomy for the ensuing ten days to two weeks provides the necessary safety valve permitting diversion of urine while healing takes place.

In conclusion, it is apparent that the physician in his present role of reluctant referee in the race between horsepower and horse sense will be called

upon frequently to treat patients with injuries involving multiple structures. It is imperative that he maintain a high degree of suspicion as to the existence of injury to the genitourinary tract and avail himself without delay of the simple diagnostic measures suitable for survey of this patient. Immediate correction of existing abnormalities may permit quick return of the patient to a useful existence. Failure to recognize the underlying injury may result in death or a degree of urologic incapacity far worse than that produced by many of the more apparent external injuries so dramatically obvious on initial inspection.

# Editorial

## THE CARE OF TRAUMA

Trauma occurs in every part of our state and is no respecter of age, sex or social position. There are many facets of the problem that properly belong to the non-medical population. This fact was emphasized at the recent Mid-Western Conference of the President's Committee on Traffic Safety. Local citizens' committees were formed to promote education in all aspects of traffic safety and to aid enforcement of existing laws. However, at this conference too, physicians were well represented because of the known interest of the American College of Surgeons in the handling of trauma.

Highway trauma is only a part of the multitude of injuries suffered by the civilian population. The additional possibility of mass casualties should alert the medical profession to the need for immediate organization for the handling of such disasters. The complacent individual who feels he is completely capable of caring for any emergency need only to read the report of the Worcester tornado to learn that almost all of the treated wounds became infected. Few know that the Flint physicians had a "practice emergency" the night prior to their second tornado. This preparation expedited the orderly care of all medical emergencies.

Wayne, Kent and Genesee Counties account for more than 50 per cent of physicians in the State of Michigan. It is conceivable that atomic attack could neutralize these countries. This would immediately force the medical care of trauma on the shoulders of the physicians in the smaller cities and rural areas. Organization now can do much to prevent chaos!

The Michigan State Medical Society for many years has fostered the postgraduate education of the practicing physicians. With such organizational "know-how" and the co-operation of institutions and groups interested in the care of trauma, the program should be a success. We have two willing medical schools in our state. The Michigan Regional Committee on Trauma of the American College of Surgeons stands ready to help at both a state and local level. This organization for several years has conducted five major educa-

tional meetings annually and many more on a local level. Much worthwhile literature on the care of trauma is available through the College of Surgeons office. The means for adequate organization and education is available. Only complacency can stop us.

HOMER M. SMATHERS.

## DUTIES WELL DONE

### Public Works AMA

One outstanding quality of the recent AMA meeting in Chicago was the meticulous discharge of responsibilities by great numbers of interested persons who served for "love of the cause." At one time, the Speaker of the House announced that there was 100 per cent attendance, not a single member being absent. The seats were seldom empty while sessions were held. The reference committees were also crowded, and most subjects which could have been controversial were well debated in committee.

Michigan had its usual active official delegation which met always for breakfast to exchange ideas and to hear reports; to visit with delegates or officers from other states. Michigan has six delegates, six alternates and one section delegate, of which one delegate and one alternate could not attend. The State may be proud of the work accomplished.

### House of Delegates MSMS

Regarding the in-state service, probably the general membership is unaware of the vast amount of time and effort needed to keep our Michigan State Medical Society in the forefront of medical statesmanship. Our House of Delegates consists of 137 members who will meet two days, September 24-25, 1956, in five sessions and sixteen reference committees which often continue until the early morning hours. These meetings precede the scientific sessions on September 26, 27 and 28.

The House of Delegates is the legislative and policy making body of the Michigan State Medical Society. At noon, on September 25, 1956, the House of Delegates constituting the membership of Michigan Medical Service conducts its annual

## EDITORIAL

meeting, including election of members of the Board of Trustees.

### The Council

The House of Delegates, while in session, is the law-making body, but the continuing work of the Society falls upon The Council which consists of eighteen district-elected representatives and six elected officers. Yearly, there are three stated meetings of the complete Council held in January, July and September, each lasting three days. The other months are provided for with one-day meetings of the Executive Committee of eleven men, held in various parts of the state. The President, President-Elect, Executive Director, Public Relations Counsel, Legal Counsel, and the Editor attend all these meetings.

Every activity of every committee or officer is reported item by item and must be approved before the action is official and binding on the Society. From seventy-five to one hundred items are considered at each meeting, involving many exhausting hours of concentration.

Only a deep love of their profession and a keen sense of duty would keep these officers active year after year. The twelve official meetings of The Council and its Executive Committee account for more than 120 hours' time, not to mention the time of numerous committee chairmen and others invited to attend and make reports, or offer technical advice.

Much of the detail work of the medical profession and the Society is delegated to over sixty committees, involving 568 members. If each member gave only one day a year, and most contribute much more, there is again about as many hours as The Council gives. When one counts up the amount of work donated by our devoted members, the figures are indeed staggering.

We believe the Society and its members really do appreciate this service when it is invited to their attention.

### MEDICAL EDUCATION

A spectacular feature of the AMA meeting in Chicago, June 10 to 16, 1956, was the presentation by F. Lee Stone, M.D., President of the Illinois State Medical Society, of a check for \$164,914 to the American Medical Education Foundation. The Illinois State Medical Society last year assessed all of their members \$20 apiece. Several state medical societies have given large amounts in the

past years. The AMA started the program with one half million dollars, which it continued for several years, but lately the contribution has been cut to \$100,000.

The American Medical Association and our members are unwilling for government to take over the education of our medical men. We fear the socializing influence which might develop, especially since the Supreme Court decision of a few years ago stating that whatever the government subsidizes it may dominate. Medical education has become much more extensive, searching and expensive. It was estimated several years ago that 10 million dollars a year are needed to augment the amounts now available to the medical schools. The American Medical Education Foundation was established and has been receiving donations from the profession and others interested, but the sum is never enough. Another appeal is now made for funds. This is a worthy and very needy cause, and every doctor is urged to make some donation each year in partial payment for the partly free education he received.

The Michigan State Medical Society also has a Foundation for Medical and Health Education which is administering loan funds to aid interns and medical students in continuing their education. A contribution to this cause is indicated.

The Beaumont Memorial Restoration Fund is still several thousand dollars in the red, and the committee would like to close its books.

These two Michigan projects were established several years ago and a good percentage of our members never had an opportunity to contribute. Both causes are worthy, and while no campaign is contemplated, contributions would be welcomed. The Beaumont Memorial will carry a listing of contributors when completed.

Someone suggested a couple of years ago that each doctor make a contribution to some or all of these funds for his anniversary or birthday remembrance. It has also been proposed that when a friend dies, especially among the doctors, we send a gift to one or the other of these worthy causes as a memorial.

Think it over, but let us all do something.

### THE HOSPITAL SERVICE PLAN OF BATTLE CREEK

The Hospital Service Plan of Battle Creek is an entirely new and pioneer concept of social service. From the very beginning of the Battle Creek Com-

munity Chest in the early nineteen twenties, the organization was rightly named "The Welfare Fund." Of the twelve to fifteen agencies making up "The Fund," almost all were engaged primarily in relief. The Boy Scouts, Camp Fire Girls and YWCA were character-building, but the Society of St. Vincent de Paul, Salvation Army Relief, Charitable Union, Community Relief and Hospital Relief were all devoted almost entirely to material relief for needy people.

At first, Nichols Hospital (now Community) and later Leila Hospital were on the lists for many thousands of dollars which were primarily to make up deficits produced by the operating on, and caring for, their charity patients. There never was an endowment fund for the hospitals and they had to do their own financing. The Welfare Fund, Community Fund, now Community Chest, supplied relief money the same as for the many other relief agencies.

During the years, and especially when more people were earning living wages, the administrators of the Community Chest were disturbed by the use of so much money to pay the bills of persons who refused to meet their own obligations, or were unable to do so. They began studies for an improvement in the service given by the hospital allotments.

During the middle thirties, the Calhoun County Medical Society made a survey, looking for methods of payment for medically indigent persons who were hospitalized. It was found that if arrangements for aid were made before the patient entered the hospital, help was often available, but not after the patient was hospitalized. The Calhoun County Medical Society found forty-four agencies in the county with available aid facilities which were limited and restricted if arranged in advance.

The Community Chest officers knew of certain social services rendered by some great hospitals, so reassigned the available money for use, not as relief but for advisory service, through the Secretary of the Community Chest. A year of trial resulted in the organization within the Chest of an entirely new group whose duties would be never to administer material relief but if possible to serve newly entered patients in hospitals if there was a question of ability to pay. Doctors were requested to consult the Hospital Service Administrator before sending the patient into the hospital—if possible.

Two years ago, an Administrative Board was organized, and Mrs. Paul Tammi was engaged and put to work. She grasped the theory of efforts and within the first nine months collected, from hundreds of different sources, enough aid for medically indigent patients to pay one of the hospitals more than the Chest had been giving them in three years' time.

She found myriads of sources of aid for the patient before hospitalization, and she has a long list of prospective people, organizations, and others that can and are willing to help when shown the need. Mrs. Tammi has developed into an angel of mercy for many who otherwise would have occupied hospital beds with no payments or extremely meager ones. Her service has grown into one of advice and counsel in many facets of community life.

Battle Creek is proud of this service effort. It is home grown and, to our knowledge, not found in any other place. The Plan is incorporated and functions with a Board of Directors. The work and services rendered are out of all proportion to the small amount budgeted, which all goes for salary and incidentals, not a cent for material relief. This relief is augmented by the Department of Social Welfare in a great many cases. The Bureau of Social Welfare Administrator was an advisor in the establishment of the service, and he is completely familiar with the work.

## HUMAN RELATIONS IN THE MEDICAL PROFESSION

*(Continued from Page 962)*

act you perform is backed by the prayers of many people, who call down God's blessing on your work. I should like to conclude by paraphrasing part of the oath and prayer of Maimonides, the great Jewish sage of Cordoba. Believe me, I say it from my heart:

"May God stand by you in your important task and grant you success. For without His loving counsel and support, man can avail but naught. May you be inspired with true love for this your great profession and for all human beings. Grant that neither greed for gain, nor thirst for fame, may interfere with your activity. For these we know are enemies of truth and love of men. May you be granted energy of both body and soul so that unhindered you will always be ready to mitigate the woes, sustain and help the rich and the poor, the good and the bad, enemy and friend. May you ever behold in the afflicted and suffering only the human being."

## A "Long Look" at the Healing Arts

It is apparent that the Michigan State Medical Society must give serious study to the attitude to be taken toward the various healing groups permitted to practice in Michigan. The definition of our attitude toward certain healers and the preparation of recommendations designed to implement that attitude have been made the responsibility of a special committee of The Council.

Healing groups that wish to practice medicine must do two things to gain full public recognition:

1. They must throw away any type of healing that stigmatizes them as a cult.
2. Their clinical teaching must be by those who are qualified to teach the science of medicine.

Only after these two basic requirements shall have been satisfied can any healing group begin to gain recognition as an orthodox profession.

Certain groups in Michigan—other than M.D.'s—are practicing medicine. It may be of a lower calibre than that practiced by the medical profession but it is nonetheless the practice of medicine. It may be illegal—but it is being done every day. This overt activity is the keystone upon which these healers base their claims for greater privilege.

My recommendation to such healers is that they substitute better teaching in their clinical years for the pressures they now exert. Better education is their critical need—not to be satisfied by any possible legislative fiat. Their clinical experiences will rise to a higher calibre only through the ethical assistance of qualified medical instructors.

These are facts with which the medical profession must reckon. A great service to the health of the people would be to help resolve this problem, especially if the aid of the medical profession is sought by these other healers.

*W.B. Jones.*

*President, Michigan State Medical Society*

*President's*



*Message*

# M S M S 91st Annual Session

## State Society Night

SHERATON-CADILLAC HOTEL, DETROIT

SEPTEMBER 26-27-28, 1956

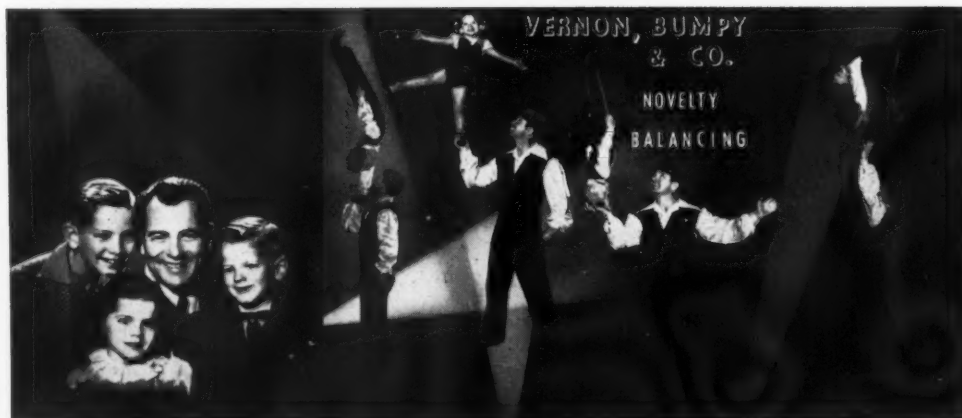


**ELMA SANTA**—A very beautiful and talented girl who will stroll with her accordion.



**JACK MARSHALL**—A very wonderful comedian and Master of Ceremonies. He has a lot of personality and showmanship. His material is exceptionally funny, he has a fine sense of timing and a brilliant delivery. He was a former Hollywood gag writer and his material is smart and refreshingly different.

**DICK KEFGEN** is an outstanding musician and entertainer. He is a handsome and personable chap and is considered to be one of the finest harmonica virtuosos in America. His repertoire includes classical numbers; currently popular numbers; and some nostalgic ones. He is quite similar to the great Larry Adler, the dean of harmonica players.



**VERNON, BUMPY AND COMPANY**—A father and his three children, ranging in age from three to eight, who perform one of the finest and most thrilling balancing and acrobatic acts in show business. After their recent appearance on the Ed Sullivan show, Mr. Sullivan said, "This, ladies and gentlemen, is one of the finest acts I have ever had the pleasure of presenting on my show." Fine praise, indeed.

# Annual Reports

## ANNUAL REPORT OF THE COUNCIL

### 1955-1956

The Council held three sessions totalling eight days, and the Executive Committee of The Council convened ten days (to September 23, 1956), a total of thirteen meetings up to the date of the 1956 Annual Session of the Michigan State Medical Society. This represented a total of 106 hours of deliberations, equivalent to thirteen days and two hours on an eight-hour working day basis, but as in the past, this total does not include additional time necessarily spent by the twenty-five members of The Council going to and returning from meetings, held in various Councilor Districts throughout the State. All matters studied (1,056 items) and recommendations made by The Council's Twenty-nine Committees as well as by the Society's nineteen Committees, and all business of the Society, were referred routinely to The Council or to its Executive Committee for consideration and action.

### Membership

Membership as of June 30, and as of December 31, from 1935 to 1956, is indicated in the following chart:

|                  | 1935 | 1945 | 1950 | 1953 | 1954 | 1955 | 1956 |
|------------------|------|------|------|------|------|------|------|
| June 30.....     | 3410 | 4425 | 4881 | 4977 | 5111 | 5503 | 5794 |
| December 31..... | 3653 | 4686 | 5114 | 5330 | 5787 | 6109 | —    |

The figures for 1956 include 5231 Active Members, 186 Emeritus and Life Members, 32 Retired Members, 345 Associate and Military Members.

### Finance

As in the past, the first item of new business on the monthly agenda of The Council or its Executive Committee is "Study of Monthly Financial Reports." Every thirty days, therefore, the Society's financial picture is reviewed and governing policies established. In addition, the Finance Committee meets periodically to study and to advise The Council on particular fiscal questions.

The auditor's report for 1955 plus the budgets of the Society for 1956 were published in JMSMS, March Number, beginning on Page 332. Members are invited to acquaint themselves with the financial status of their State Medical Society and to offer suggestions; these always are truly appreciated. As of June 30, 1956, 5231 members paid Society dues amounting to \$148,905.50. This was on the basis of \$28.50 per member allocated to the General Fund as established by The Council in January, 1956, and includes some payments by new members of portions of a year. Also, \$26,115.00 accrued to the Public Education Reserve Account, \$32,643.76 accrued to the Public Education Account, \$18,280.50 accrued to the Public Service Account, and \$27,420.74 accrued to the Professional Relations Account, for current activities as directed by The Council in January, 1956. The sum of \$10,446.00 was set aside in a Building Fund as well as \$15,669.00 in a contingent surplus fund. A brief financial résumé of each of the MSMS activities as of June 30, 1956, is presented in the accompanying table.

The AMA dues collected by county medical societies, forwarded to MSMS, and then mailed to the American Medical Association during the six months to June 30, 1956, totalled \$128,300.00. The very high percentage of AMA dues being paid by MSMS members (98.1 per cent) is to be noted; The Council feels that the members of our State Society are to be congratulated on their tangible cooperation with and support of the American Medical Association. A résumé of the financial condition of the Michigan State Medical Society as of August 31, 1956, will be presented to the House of Delegates at its opening session of September 24, 1956, as a part of The Council's Supplemental Report.

AUGUST, 1956

## Financial Report for Period Ending June 30, 1956

| ACCOUNT                              | On Hand<br>1/1/56 | Income to<br>7/1/56 | Expenses to<br>7/1/56 | Balance on<br>Hand 7/1/56 |
|--------------------------------------|-------------------|---------------------|-----------------------|---------------------------|
| General Fund.....                    | \$ 77,593.98      | \$151,115.18        | \$ 83,971.16          | \$144,738.00              |
| Annual Session .....                 | —o—               | 23,622.50           | 2,944.62              | 20,677.88                 |
| Michigan Clinical<br>Institute ..... | —o—               | 13,210.00           | 12,733.42             | 476.58                    |
| The Journal .....                    | —o—               | 40,304.99           | 37,215.21             | 3,089.78                  |
| Public Education ..                  | 76,494.02         | 32,738.71           | 21,840.55             | 87,392.18                 |
| Public Service .....                 | 281.28            | 18,280.50           | 5,252.03              | 13,309.75                 |
| Professional Rela-<br>tions .....    | 6,805.30          | 27,420.74           | 16,955.82             | 17,270.22                 |
| Public Education<br>Reserve .....    | 30,000.00         | 26,115.00           | —o—                   | 56,115.00                 |
| Rheumatic Fever<br>Control .....     | 22,704.24         | 10,000.00           | 13,575.68             | 19,128.56                 |
| Surplus from Dues ..                 | 37,267.34         | 15,669.00           | —o—                   | 52,936.34                 |
| Building Fund.....                   | 13,788.46         | 10,446.00           | 4,912.42              | 19,322.04                 |
| Beaumont Memorial<br>Fund .....      | -9,790.29         | 691.00              | —o—                   | -9,099.29                 |
| TOTALS .....                         | \$255,144.33      | \$369,613.62        | \$199,400.91          | \$425,357.04              |

Thus far in 1956, \$48,539.06 of the funds of the Michigan State Medical Society have been invested in short-term securities. These funds are invested during the early part of the year when income resulting from dues payments is high and thus earn interest for the commercial account. These securities mature later in the year when income is low and expenses continue at the regular rate. Any securities maturing, the funds from which are not immediately required, will be re-invested upon the advice of the Finance Committee. Interest income from securities held by the Michigan State Medical Society has accrued during the first six months of 1956 in the amount of \$1,010.93.

### The Journal

Fifty-five years ago, the newly-created Officers and Councilors of the Michigan State Medical Society with the late Dr. Andrew P. Biddle serving as Editor, foresaw the great advantage of a monthly contact with the membership instead of the previous yearly publication, "The Transactions." THE JOURNAL furnished a medium of communication of all the materials and actions of the parent State Society and was distributed monthly along with reports, news, editorial messages combined with scientific papers. The project paid in multiples as evidenced by the growing Society and the interest in medical and socio-economic affairs.

THE JOURNAL was founded on the "house organ" theory and has been completely successful. It has grown from a small "patent medicine" affair with a few hundred copies each month, to as many thousands with over 1,500 pages, a supplement directory, ambitious composition, art work and extensive recognition of the various activities of the medical profession. Almost every number is dedicated to different activities of our profession with editorial material, news, reports and special articles featuring the special topic of dedication.

For several years, we have devoted THE JOURNAL covers to divergent and essential activities of special departments, committees or economic and socio-medical concern. Every cover is individually designed to represent some activity or special interest, in two or more colors, and all have attracted wide notice among other editors. We are proud of our diversified interest and challenging cover display. Our August, 1955, JOURNAL was devoted to Industrial Medicine and featured a factory with a doctor in the foreground, in September the Collier-Penberthy Clinic with the cover featuring the sponsor, Dr. E. L. Thirlby of Traverse City. October was devoted to the Generalist and November to Tuberculosis

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using the Christmas Seals on the cover. In December it was the Michigan Clinical Institute and the theme "Doctor, Don't Be Left Outside;" Heart and Rheumatic Fever with a dramatic cover showing two hands pulling at a chain to show the chain can be broken, was the January number; February honored the University of Michigan Medical School, and March honored Wayne State University College of Medicine, both covers featuring campus buildings as the background; April was devoted to Cancer Control with the cover depicting three swords as the weapons against cancer: education, research and service; May stressed a rural scene and the new doctor and was devoted to the Michigan Foundation for Medical and Health Education; the June issue was dedicated to Michigan Medical Service and featured the Blue Shield; July was the Annual Session number, and August—Trauma.

We have continued our editorial emphasis on medical and socio-economic questions involving the welfare of our profession. All editorials involving policy and economic trends are previously submitted in preliminary form to the Publication Committee, plus a selected group of officers and specially interested or informed persons, in the belief that the thoughts expressed should reflect the opinions and approval of others as well as of the Editor.

For the most part, scientific editorials have been left to some specially designated writer while book reviews, news, and features have been the responsibility of the Editor. Special assistants have been designated for certain Numbers and their work has been most welcome and helpful and we are grateful to them.

The editorial tasks and responsibilities have been continuously encouraged and vastly assisted by the Publication Committee, the Executive Committee and numerous helpful friends to all of whom the Editor confesses obligation. The numbers of THE JOURNAL for the coming year have been in some measure allocated, but some are still available to feature some special activity which members may wish to suggest.

### Organization

1. The Annual County Secretaries—Public Relations Seminar—a three-day indoctrinational course—was held in Detroit on January 27, 28, 29, 1956, with 151 attending. The general consensus of those attending was "it was the best."

"So You've Been Elected"—a new "bible" of county society organization—made its debut at the 1956 Seminar. This highly illustrated handbook of medical society teamwork, produced by the Michigan State Medical Society, is intended to make it easier for county society officers to assume with greatest effectiveness the responsibilities of component society leadership.

2. The Tenth Michigan Clinical Institute was held in Detroit March 7-8-9, 1956, with an attendance of 2,475, including 1,421 M.D.'s. The popularity of the MCI, as a purely scientific or postgraduate medical meeting, improves year after year.

3. The usual semi-annual meetings of the seven Delegates from Michigan to the American Medical Association House of Delegates, including Grover C. Penberthy, M.D., Detroit, AMA Surgical Section Delegate, as well as the six Alternate Delegates, were held with the Executive Committee of The Council immediately prior to the June and December sessions of the AMA. Our Delegates and Alternates are doing efficient work and are gaining well-merited recognition in the AMA House of Delegates.

4. The Residents-Interns-Senior Medical Students Conference again was held in Detroit, March 7, 1956, coincident with the Michigan Clinical Institute.

MSMS again sponsored financially the sending of Delegates from Michigan's two medical schools to the Student AMA Convention in Chicago in May, 1956.

5. The 90th MSMS Annual Session in Grand Rapids, September 28-29-30, 1955, attracted a record registration—for Grand Rapids—of 3,585, including 1,671 M.D.'s.

An innovation at the 1956 (91st) Annual Session, scheduled for Detroit September 26-27-28, will be the "Officers Night Banquet," scheduled for Wednesday evening, sponsored jointly by MSMS and its Woman's Auxiliary.

6. More national medical leaders from Michigan are gaining recognition; during the 1956 Michigan Clinical Institute, nine Michigan doctors of medicine were honored for achieving during the past year the presidency of national medical associations:

William H. Beierwaltes, M.D., Ann Arbor—American Federation for Clinical Research

Arthur C. Curtis, M.D., Ann Arbor—American Board of Dermatology and Syphilology

Russell N. DeJong, M.D., Ann Arbor—American League Against Epilepsy

Thomas Francis, Jr., M.D., Ann Arbor—American Epidemiological Society

A. C. Furstenberg, M.D., Ann Arbor—American Academy of Ophthalmology and Otolaryngology

Clarence S. Livingood, M.D., Detroit—Society of Investigative Dermatology

Richard H. Meade, M.D., Grand Rapids—American Association for Thoracic Surgery

Frederic Schreiber, M.D., Detroit—Harvey Cushing Society

Wolf W. Zuelzer, M.D., Detroit—Society for Pediatric Research

7. During the past year, W. S. Stinson, M.D., Bay City, was appointed as Councilor of the Tenth District to serve the unexpired term of F. H. Drummond, M.D., Kawkawlin, resigned.

8. Modern handling of MSMS membership records. During recent months, The Council approved a change-over from the old Kardex system to IBM records covering the MSMS membership, to achieve more efficiency in the State Society headquarters as well as to aid county medical societies in their arduous task of billing for membership dues (county, state, and AMA). The new system was explained to all county society officers at the Councilor District Conferences held throughout the State this summer.

Inasmuch as all membership billing will be done by the Michigan State Medical Society and the county society secretary will be relieved of this former detail work, the 1 per cent collection credit now remitted to component societies should be used by MSMS to offset the expense of the additional investment and maintenance of the efficient IBM system.

*A recommendation on this subject follows.*

9. Organization among the fifty-five component county societies, covering all of Michigan's eighty-three counties, was well maintained during the past year. The scientific side of medicine in this state continues at an all time high.

MSMS is gratified at the increased interest in socio-economic matters on the part of its component societies, evidenced by many more requests to the State Society for assistance (examples: many invitations to State Society officers, especially President W. S. Jones, M.D., for personal appearances before component societies; and far more questions referred to MSMS for legal opinion from our Legal Counsel.)

### Public Relations

Attitudes antagonistic to the private practice of medicine continue to crop up frequently in legislative chambers, both state and national, at the industrial bargaining table, in newspaper and magazine headlines, and in the public statements of various figures who have many personal followers. These continued undercurrents prompt a deeper awareness of the need for good public relations. Since the ultimate purpose of all MSMS public relations efforts is to maintain freedom in medicine, a consciousness of public relations is necessary in the development of almost every activity of your State Medical Society. The Society has repeatedly

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re-evaluated its policy in almost every field in the light of its public relations impact.

Since it penetrates so deeply into the activities of our Society, public relations no longer can be measured wholly in terms of inches of newspaper space, hours of radio and television time, the number of speakers before groups of community leaders, and other such gauges used at times in the past. Such methods of mass communication maintain their importance—and their volume and success continues to be impressive (see PR Committee Report). But other less obvious factors are of growing effectiveness in the promotion of good public relations for MSMS and the medical profession. Numbered among these are such items as the stronger relationships built year by year with professions and organizations who share with Medicine a great stake in preserving American freedom, better understanding within our own profession of the future aims and achievements of medical organization, the atmosphere of trust within our state government and with the Legislature which have accumulated to MSMS through the years, and the teamwork evident in county society co-operation with MSMS.

Several new steps have been taken during the year to promote this new depth of PR penetration. Noteworthy was the publication of a handsome brochure called "Progress . . . Because Doctors Work Together" which for the first time tied together the goals, achievements, and services of MSMS, and the scope and structure of medical organization. This booklet, initially distributed to all MSMS members and now being sent individually to each new member, is a summary which gives new perspective to participation in the affairs of MSMS.

Meetings with officers and key members of county medical societies continued throughout the state in the interest of stimulating local public relations programs and the use of services and facilities of MSMS in carrying out such programs. The internal strength of medical organization in Michigan was greatly furthered by the intensive schedule of speaking appearances by President W. S. Jones, M.D., before county societies and hospital staffs in every section of the state.

Worthy of special mention was MSMS participation in the first nationwide observance of Medical Education Week. This observance was the springboard used to launch great quantities of information on progressive efforts of the medical profession to increase medical service and to improve medical practice in Michigan.

Establishment of a Public Relations library at MSMS headquarters in Lansing was authorized and work was begun to catalogue the thousands of items of public relations information and tools accumulated by MSMS in recent years. When set up in proper form, the library will be an efficient source useful in future PR planning.

During the long legislative session of 1956, again the medical profession lost none of its freedom in Michigan, and standards of medical care were maintained in the face of numerous threats. Quality health care for the people of Michigan remained untouched, even though sub-standard healing groups waged intensive campaigns to increase their privileges by legislative fiat.

Since the future strength of medical organization and the preservation of medical freedom in the next decade depends upon the coming generation of doctors of medicine, MSMS during the past year stepped up its work with future physicians. In close collaboration with the state's two medical schools, MSMS took steps to intensify the education of medical students in medical economics and the social implications of private practice in Michigan. This is an area to which we must devote much time and attention, building upon what is now but the groundwork for the type of program which should be carried out.

Unless we consider effective public relations activity as merely a delaying action in the struggle to preserve the private practice of medicine, a consciousness of public relations should penetrate far deeper into every facet

of MSMS program planning and execution, even in those areas which on the surface appear to be purely scientific in nature. In government, in industry, and in community life today even the conservative elements entertain many ideas which if carried to the ultimate could greatly curtail the freedom of the medical profession to the detriment of the people it serves. The threat of the ill-informed "conservative" who unknowingly or unthinkingly chisels away at medical freedom may in the future present a greater problem than the so-called "liberal" who is outspoken in his intentions and whose goal has been spelled out openly. We refer to the businessman who fails to support the principles of professional men as opposed to some union leaders who seek to place professions into the category of governmentally-controlled public utilities.

At every opportunity in every relationship, the medical profession, collectively and individually, must understand the profession's public relations responsibilities—and fulfill them—if the people we serve are to continue to benefit from medical freedom.

### Woman's Auxiliary

The Woman's Auxiliary to the MSMS has had "a good year"—a stimulating and enlightening year—and above all, one of excellent co-operation and combined efforts. Each auxiliary has, in some way, done outstanding work and has contributed greatly to the projects of the state and national auxiliary. It is regrettable that each cannot be cited separately.

The year has been punctuated with many notable achievements—a few of which are:

*Fifty Organized Auxiliaries*—with a membership of 3,059 and 287 new members.

*American Medical Education Foundation*—a contribution of \$3,200.00—an increase of 23 per cent over last year and an average of over \$1.14 per member. In addition, Michigan was among the "top ten states" in the 80 Dimes Campaign—with \$665.50 raised.

*Nurse Recruitment* takes top billing with all our auxiliaries—each participating in some way in this project. \$11,349.73 was spent for recruitment activities—with \$486.08 for Future Nurse Clubs;—\$3,538.65 for Loans;—and \$7,325.00 for Scholarships. This was an increase of 28 per cent—or an increase of over \$2,500.00 from last year.

*Today's Health*—88 per cent of our state quota. An increase of 13 per cent. Fourteen auxiliaries reached 100 per cent or better. Mason County Auxiliary—with a membership of nine—reached the almost unbelievable heights of 1,922 per cent; for which it received a check for \$25.00—second prize nationally in the 1955-56 Subscription Contest. In addition, Michigan was honored at the Second Annual *Today's Health* Breakfast held in Chicago during the convention in June.

*Annual Tuberculosis Speaking Project*—A total of 3,465 students from eighty-seven schools scattered over forty Michigan counties participated in this project, sponsored jointly by the Michigan Tuberculosis Association and the Woman's Auxiliary to the Michigan State Medical Society. One hundred and sixty talks were submitted for state judging. Students spoke to school and community audiences totalling about 13,115; with local radio programs, about forty, arranged by schools or local county auxiliaries.

A survey of the various Volunteer Services given by doctors' wives in their respective communities brought forth this result: based on returns from 30 auxiliaries—a conservative estimate was 35 hours per member per month. Outstanding public relations and again evidence that doctors' wives more than carry their share of responsibility.

The auxiliaries responded effectively to the request of the MSMS for sending letters and telegrams re Bill HR 7225; and have kept informed as to the status of bills suggested for our study by the AMA this year.

Increased interest in Civil Defense, Mental Health,

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and Safety has been shown—many auxiliaries having programs devoted to these subjects.

There are many more accomplishments, but suffice to say—"It's been a good year." Our Woman's Auxiliary should be as proud (as is The Council) of its own accomplishment!

### Contact with Governmental Agencies

An important activity of the Michigan State Medical Society continues to be necessary contacts with federal, state, and local governmental agencies. The most significant contacts made during the past year were:

1. Michigan Day in Washington, D. C. Again, MSMS representatives visited Washington, D. C., on May 1, 1956, pursuant to instructions of the 1955 House of Delegates, to make personal contacts with our friends in the Capitol and in the administrative offices of the federal government, with resulting increase in good will. *A recommendation on this subject follows.*

2. Pleasant contacts with the State Executive Office in Lansing were maintained as the result of the creation last year of a Liaison Committee with the Governor. The following matters were subjects of discussion: (a) Nominations for the Michigan State Board of Registration in Medicine; (b) MSMS representation for the Governor's Study Commission on Prepaid Hospital Care Plans—the subject of serious discussion at four meetings of The Council and its Executive Committee; (c) Doctor availability; (d) Hospital facilities; (e) Medical education and the necessity for additional facilities in Michigan; and (f) MSMS opinion on health proposals which the Governor placed before the 1956 Legislature.

3. Michigan State Board of Registration in Medicine. E. C. Swanson, M.D., of Vassar, was appointed Secretary of this Board during the past year. He immediately requested the appointment of a liaison committee from the Michigan State Medical Society to advise him on problems concerned with medical practice; the Committee was appointed and several productive meetings have been held. One of the subjects considered was annual registration of doctors of medicine by the Michigan State Board of Registration in Medicine. According to Secretary Swanson, thirty-eight states have such a system which has proven beneficial.

The Council respectfully requests the House of Delegates to consider this question: Shall the Michigan State Medical Society favor or be opposed to annual registration of doctors of medicine. (A bill presented to the 1956 Michigan Legislature to inaugurate annual registration of M.D.'s was not pressed for action, pending decision by the Michigan State Medical Society House of Delegates.)

4. Liaison with the Michigan Commissioner of Health continues to be frequent, with Commissioner A. E. Heustis, M.D., being invited to all meetings of The Council and of its Executive Committee to report and discuss interesting factors and problems of mutual interest in the field of preventive medicine.

5. Recently, the Veterans Administration "Home Town Medical Care Program" was ordered cancelled as of July 1, 1957. A protest was made by the Michigan State Medical Society et al which sent representatives to Washington, D. C., to meet with Veterans Administrator H. V. Higley and Medical Director Wm. S. Middleton, M.D. After several months' negotiations, The Council is happy to advise, that, through the personal intercession of Administrator Higley, the "Home Town Medical Care Program" is to be continued, so far as Michigan is concerned. The congratulations and thanks of the Michigan State Medical Society have been dispatched to Administrator Higley for his judicious decision in this matter—his ruling insures that veterans in Michigan are given the best of medical care in their own localities. The Council also expresses gratitude to the veterans organizations of Michigan for their support of the MSMS in their stand.

6. Group Medical Care Enabling Act. Attorney General Thomas M. Kavanagh delivered an opinion on April 18, 1956, that Section 8 of Act 108 of the Public Acts of 1939—under which Michigan Medical Service is organized—which requires that "the majority of directors shall be at all times persons approved by the officers of the medical profession duly organized to promote statewide the science and art of medicine"—is "uncertain, indefinite, and vague, and therefore inoperative." The MSMS attitude toward the recent suggestion of some segments of the UAW-CIO to start a medical service plan of its own should be one of watchful waiting.

7. The usual number of beneficial contacts were maintained during the past year with the University of Michigan (which in April announced its plans for the physical examination of medical students by their family doctors); Wayne State University College of Medicine; Ferris Institute; Michigan Crippled Children Commission—which sought the advice of MSMS on numerous medical problems; Michigan Social Welfare Commission; Michigan Department of Insurance; members of the United States Congress; and members of the Michigan Legislature (see paragraph on Public Relations and Legislation).

### Contacts with Voluntary Agencies and Organizations

1. Newly elected officers of Michigan Medical Service during the past year included Wilfrid Haughey, M.D., Battle Creek, President, and L. Fernald Foster, M.D., Bay City, Vice President. Michigan Medical Service continues to enjoy great success in its 16th year of existence. Financial reports of Michigan Medical Service will be submitted to its Members at their Annual Meeting of Tuesday, September 25, 1956, 2:00 p.m. in the MMS Headquarters, 441 E. Jefferson Street, Detroit. President Haughey urges all MSMS Delegates (who *ipso facto* are Members of Michigan Medical Service) to be present at this session to insure a quorum necessary for the conduct of business, and to learn more about the corporation entrusted to them in behalf of the public. This information is what the medical profession and the people desire to know.

At the request of Michigan Medical Service, a special MSMS "Committee on Michigan Medical Service" was appointed during the past year to advise on medical problems facing the Michigan Medical Service administration. This Committee considers recommendations of both doctors of medicine and subscribers to Michigan Medical Service.

A full page advertisement entitled "What is the Difference Between Blue Shield and Blue Cross?" was placed in the *Detroit Free Press*, *Detroit Times*, and *Detroit News*, the *Grand Rapids Herald*, *Grand Rapids Press*, and the *Lansing State Journal* on April 22, during Medical Education Week.

2. Closer liaison with the State Bar of Michigan was effected during the past year with the creation of a joint committee which held two meetings to draft an interprofessional guide between the medical profession and attorneys.

3. The Hospital Relations Committee, with representatives from the Michigan State Medical Society and the Michigan Hospital Association, held several meetings during the past year to discuss problems mutual to both the medical profession and the hospitals of this state.

4. Favorable liaison also exists between the Michigan State Medical Society and the Michigan State Nurses Association—the Detroit Division of the MSNA co-sponsoring with MSMS the Operating Room Supervisors Conference held coincident with the Michigan Clinical Institute; Michigan Health Council; Michigan State Medical Assistants Society—which was active in organizing the American Association of Medical Assistants at the organizational meeting in Kansas City last November;

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the Michigan Tuberculosis Association; the Student AMA, et cetera.

5. Too numerous to mention are the voluntary organizations which invited the Michigan State Medical Society to name representatives to their boards and committees or at their meetings and conferences during the past year. The Council expresses its sincere thanks to all MSMS members who sacrificed valuable time and effort to act as official MSMS representatives to these many organizations.

### Beaumont Memorial Restoration

Additional furnishings for the Beaumont Memorial—particularly for the store—were obtained during the past year. The State Society is especially grateful to Mrs. Carroll Paul of Marquette for her interest and tangible help in making this museum more attractive; also to the Michigan Historical Commission and Lewis Beeson, Executive Secretary of the Commission, for valuable advice and guidance in developing the Beaumont Memorial as a great historical shrine.

To reimburse the Michigan State Medical Society for its financial help in building the Beaumont Memorial, the sum of \$9,099.29 is needed. Less than 50 per cent of MSMS members have contributed to the building of the Memorial—an architectural and historical gem which belongs to all members of the medical profession and should be the financial responsibility of all practitioners.

*A recommendation on this subject follows.*

### Committees

A total of eighty-eight meetings of Committees of the Michigan State Medical Society and of The Council were held during the past year (up to September 1, 1956).

These active groups continue to be the backbone of the progress of the Michigan State Medical Society. The Council commends to the careful perusal of all MSMS members the annual reports of all committees. It expresses true gratitude to the chairmen and members of these committees for their great and unrewarded contributions of time and effort given on behalf of all MSMS members—for the benefit of Medicine and the public of Michigan.

Especially active during the past year were the following committees: Child Welfare Committee; Geriatrics Committee; Committee on Michigan Medical Service; Health and Accident Insurance Policy Control Committee; Legislative Committee; Mental Health Committee; National Defense Committee; Permanent Conference Committee; Rheumatic Fever Control Committee; Rural Medical Service Committee; Committee on Study of MMS Fee Schedules, and Maternal Health Committee.

The Arbitration Committee, which deals with the Uniform Fee Schedule for Governmental Agencies (which has not been revised since December 1, 1949) met frequently during the past twelve months.

*A recommendation on this subject follows.*

The Committee on Welfare Package Deals. This Committee was recently created to study various plans currently in practice in many counties of Michigan for the medical care of welfare and medically indigent patients. From data supplied by the component county societies, this Committee hopes to ascertain—purely for study purposes—how much is paid, how payment is made, and if each county society is satisfied with the relative equity of its own arrangement. This study of various arrangements in existence in Michigan will be valuable and helpful information.

### Annual Reports of Committees of The Council

To save the time of House of Delegates' Reference Committees, the Annual Reports of Committees of The Council are being integrated into the Annual Report of The Council—a pattern that was successfully inaugurated last year:

August, 1956

*Liaison Committee with Michigan State Pharmaceutical Association.*—No problems have arisen during this year that required a meeting of this Committee. Some members of the Committee assisted in the classification of a related problem involving the Michigan State Pharmaceutical Association, the State Board of Pharmacy, the Michigan State Nurses Association, and Michigan Hospital Association.

*Permanent Conference Committee with Michigan Hospital Association, Michigan League for Nursing, and Michigan State Nurses Association.*—The Permanent Conference Committee has held regular meetings which have been well attended not only by our members but the members from the other component groups. Some of the major problems which were discussed follow:

1. Recruitment of Medical Record Librarians
2. Hospital Pharmacy Operation
3. Psychiatric Nursing
4. Patient Care
5. Defense Aid Mobilization
6. Nurse Aid Training Programs
7. Current Legislation
8. Blue Cross-Blue Shield Problems
9. Rehabilitation Programs

It is pleasing to note that this Committee has made definite progress during the years of its existence. All component organizations are much closer together and the attitude of all the representatives is very cooperative. Most problems are common to all groups and we all benefit through thorough discussion of all viewpoints.

*Committee on Awards.*—During the past year, the Committee on Awards has carefully reviewed possibilities for public recognition by the Michigan State Medical Society of outstanding work done in behalf of the health of the people of Michigan and the medical profession.

As a result, we have during the past year recommended the citations noted below. These recommendations were formally approved by The Council and were publicly presented.

At the 90th Annual Session of the MSMS:

1. James Gerity, Jr., Adrian, President of WNEM-TV, Bay City, for distinguished service in public education through the medium of television.
2. Jean Worth, Escanaba, Editor of the *Escanaba Press*, for distinguished contribution to public understanding of Medicine and Health.
3. Wilfrid Haughey, M.D., Battle Creek, Editor of THE JOURNAL of the Michigan State Medical Society, in appreciation for many years of dedicated service.

At the Michigan Clinical Institute:

1. Robert L. Novy, M.D., of Detroit, President of Michigan Medical Service (Blue Shield) for fourteen years until last July, received mementoes from both Blue Shield and MSMS.
2. Nine MSMS members serving as presidents of national medical organizations.
3. Frederick F. Yonkman, M.D., Summit, New Jersey, Vice President of Ciba Pharmaceutical Products, Inc., honored jointly by MSMS and the Michigan State Pharmaceutical Association as official representative of the drug manufacturing industry.
4. The MSMS Award for Excellence in Medical Reporting, top honor in the news field, went to the *Detroit Free Press*, represented by Managing Editor Frank Angelo, with a supporting award to Mrs. Jean Pearson, *Free Press* science writer.
5. Distinguished Health Service Awards were presented to: John Wurz, Editor of *The Grand Rapids Herald*; the *Lansing State Journal*; the *Muskegon Chronicle*; WJBK and WJBK-TV, Detroit; WPAG and WPAG-TV, Ann Arbor; WKZO and The Drug Shop, Kalamazoo; WHFB and Gillespie's Drug Store, Benton Harbor-St. Joseph, and The Upjohn Company, Kalamazoo.

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Although not within the scope of this Committee's responsibility, the Committee nonetheless recognized with pleasure: the election of Walter H. Winchester, M.D., as Michigan's Foremost Family Physician of 1955; the 18 MSMS members representing 900 years of Medical Service, who were presented with the Fifty-Year Award this year; the Biddle Lecturer, Dr. Charles L. Anspach, Mt. Pleasant, President of Central Michigan College of Education, and the Annual Beaumont Lecturer, Garnet W. Ault, M.D., Washington, D. C.

**Committee on Courses on Medical Economics and Ethics.**—The full Committee met on August 26, 1955, to prepare the outline of the subjects to be presented for the following year, and the minutes of this meeting were accepted by The Council on September 25. During this meeting the work of the previous year was reviewed and a program developed for the following year. It was suggested that the Chairman write up a synopsis of each talk so that the students would have a little better idea of what the subject was about. This was done and some of the lectures were combined so that twenty subjects were presented for consideration along with a brief abstract of what would be covered in the talk. Eighteen of these subjects were selected and presented.

**July 6, 1955: "Medical Public Relations"**—Dr. R. W. Teed. This lecture covered briefly the whole field of medical public relations including the fundamental personal factors of the physician, public relations of the office level, at the county society level, at the state and national levels. It was intended only as a brief review of the entire problem.

**July 13, 1955: "Practice in a Small Community"**—Dr. J. S. DeTar of Milan. This lecture covered some of the conditions seen by the practitioner in the small community, his equipment and his methods of operation.

**July 20, 1955: "The Doctor Draft"**—Captain Brunk of the State Selective Service Administration. Captain Brunk gave a review of the selective service law and its application to physicians.

**October 5, 1955: "Physician Placement in Michigan"**—Mr. E. H. Wiard, Executive Secretary of the Michigan Health Council, Lansing. Mr. Wiard gave a review of the work of the M.D. placement program which was transferred from the Michigan State Medical Society to the Michigan Health Council two years ago and has been under the partial sponsorship of the Upjohn Company of Kalamazoo. He reviewed the work which has already been done and acquainted the students with the facilities which are available whenever they are ready to go about the business of selecting a place to practice.

**November 9, 1955: "The Relation of the Physician to the Legislature"**—Dr. L. A. Drolett, Chairman of the Legislative Committee, MSMS. Dr. Drolett reviewed the work of the Legislative Committee of the MSMS along with that of the Public Relations Department in dealing with the rather large number of bills with medical interest which are annually presented to the Legislature. He pointed out that approximately 10 per cent of all bills presented have medical interest. He stressed the need of the physicians to take an interest in the legislators of their home districts in order to advise them adequately on medical matters in relation to law.

**November 16, 1955: Open session of the Ethics Committee of the Washtenaw County Medical Society.**—On this day the Committee held what was essentially an open session, several applicants for membership being present. It is a requirement of the Washtenaw County Medical Society that each member meet with the Ethics Committee for an indoctrination and the students were thus able to see what actually goes on at such a session.

**November 16, 1955: "Rural Practice Can Be Fun"**—John R. Rodger, M.D., of Bellaire. Talk to the sophomores. In giving the talk, Dr. Rodger attempted to answer three questions: 1. Can I practice good medicine in the community? 2. Will I make a decent living there? 3. Will I and my family enjoy living there?

The talk also covered the co-operation of the family physician and the specialist, and the service that the specialist in the trading center gives to the rural physician in that area.

**November 23, 1955: "The Relation of the Physician to Other Practitioners"**—Dr. M. R. Weed of Detroit. Dr. Weed reviewed the various problems which periodically arise with other practitioners, especially in connection with refer consultations, etc., and suggested acceptable methods of carrying out these procedures. He also discussed briefly the technical consideration in contacts involving cultists.

**December 7, 1955: "Self Policing of the Medical Profession"**—Dr. James Blodgett of Detroit. Dr. Blodgett described the operation of the various means of self policing in the profession such as (1) the surgical audit society, (2) the medical audit committee of the hospital, and (3) the tissue committee of the hospital. By these means the profession is attempting to not only keep its own house clean but to improve the standards of the practice in the entire State of Michigan.

**January 4, 1956: "The Program of the Michigan State Public Relations Department"**—Mr. Hugh W. Brenneman and Mr. DeWitt Brewer. This program was handled very nicely with one speaker covering one subject and then the other taking over for another subject. The alternately changing voices definitely increased the listening appeal and the students were given a clear picture of what the MSMS is attempting to do along the lines of public relations. Stressed also was the need of good public relations at the office level.

**January 11, 1956: "Office Records"**—Dr. R. W. Teed. On this date a storm prevented the appearance of the scheduled speaker and the Chairman filled in with the methods of keeping accurate and adequate office records.

**January 18, 1956: "Medical Ethics"**—Dr. Glen Coan of Wyandotte. Dr. Coan is a member of the Ethics Committee of the Wayne County Medical Society. He presented cases that had been reviewed by the Committee and pointed out how difficulty could have been prevented.

**February 1, 1956: "Starting a Practice"**—Dr. Warren Mullen of Pentwater. Dr. Mullen who started practice only a short time ago still has in mind the problems entailed in such a venture and described these very clearly to the students.

**February 20, 1956: "The History, Philosophy and Proper Utilization of Blue Cross-Blue Shield"**—Dr. L. Fernald Foster of Bay City. Dr. Foster gave a brief review of the history of the facts which led to the adoption of Blue Cross-Blue Shield in Michigan and pointed out that although the present generation knows nothing of these problems, the heritage which has been left by farsighted men of the past should not be accepted as a matter of course. The philosophy also behind the adoption and continued co-operation of Blue Shield was outlined, and some of the factors concerned in utilization were also discussed. He pointed out that it was the responsibility of the medical profession to make sure that Blue Cross-Blue Shield were kept solvent since they represent the major answer of the profession to the socialization of medicine.

**March 14, 1956: "Health Coverage of the Community"**—Dr. Hugh Robbins of Battle Creek. Dr. Robbins reviewed the routine operations of the health department and pointed out the responsibilities of the health department to the physician and vice versa.

**April 4, 1956: "Problems of Veterans' Care"**—Dr. William Bromme of Detroit. Dr. Bromme, who has been active in the study of veterans' problems of the MSMS, gave a review of this and pointed out reasons why the society is opposed to the further extension of non-service connected care.

**May 2, 1956: "The Development of a Fee Schedule"**—Dr. Arch Walls of Detroit. Dr. Walls reviewed the factors concerned in the running of a medical practice and discussed both the practical and philosophical aspects of the development of a fee schedule.

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**May 16, 1956:** "Approaches to Health Coverage for the Public"—Mr. Jay Ketchum, Executive Vice President of Michigan Medical Service. Mr. Ketchum described not only the coverage of Blue Shield but also other approaches to the problem such as the closed panel, union clinics, socialized medicine, et cetera.

**May 23, 1956:** "Provincialism and Economic Realism"—Dr. Jackson Livesay of Flint. Dr. Livesay pointed out that while physicians make a good living and are entitled to this, there is a certain sense in which this prosperity can be flaunted before the public and a bad public relation result. He pointed out methods of obviating this fault.

In addition, the Committee arranged a court demonstration in co-operation with Professor Charles Joiner of the University of Michigan Law School, and since the students stated they would prefer to have some of their own members take part in this activity the matter was turned over to them. However, in the shuffle the contact was lost, and no demonstration was put on.

The Chairman would like at this time to commend and thank all members of the Committee for their aid and suggestions in working out this program. He would also like to express profound gratitude to all of the men who co-operated in presenting the lectures. He would like to point out that during the past four or five years he has been in charge of the program that not one single member of MSMS has refused to accept his duties. In all cases it represented an interruption in the physician's busy practice and a considerable expenditure of effort since many of the men came from considerable distances. Obviously, the programs could not have been put on without this co-operation, and the Committee recommends that The Council find some way of expressing appreciation for the work of these men.

**Arbitration Committee.**—The Committee on Arbitration attempts to advise fair, equitable and uniform fees for certain medical services rendered to Governmental Agencies. As of the present date, the Committee has had three meetings and reviewed forty cases, including four cases which were held in abeyance from the 1954-55 meetings. Judging from past experience, we will have about two more formal meetings before the close of the year.

**Committee on National Defense.**—The most important business taken up by the Committee in the past year concerned the establishing of a full-time National Defense Medical Office in the Department of the State Board of Health. Doctor Heustis, Director of the State Board of Health, is the representative in the State National Defense Organization. It is felt that the doctors and other medical personnel should have someone in that office who can take care of the correspondence and the correlation of the other departments throughout the state in this work. As it is, we have meetings which are constructive and instructive but no central office through which the work can be executed.

**Liaison Committee with Michigan Veterans Organizations.**—The Chief Medical Officer of the Veterans Administration indicated in October, 1955, his intent to discontinue the Michigan Home Town Care Program for Veterans on July 1, 1957. Strong representations made before V. A. Administrator by a group representing the MSMS, Michigan Veterans organizations and the Michigan Congressional delegation produced, on May 18, 1956, an announcement of reversal of this position. Accordingly, the Michigan Home Town Care Program has been granted a continuation for an indeterminate period. It was not necessary to utilize the Liaison Committee for this project.

**Committee on Atomic and Allied Procedures.**—During the past year this committee has had no official meeting. Several members have met informally for discussion of matters which might properly come before this group. Our conclusions might be summed up as follows:

(1) At the time this committee was organized, there

was a definite need for a broadly representative group to correlate and evaluate the data on the uses of atomic energy both constructively and destructively.

(2) During the years the destructive effects of mass radiation together with methods for protection and control have been taken over by Civilian Defense.

(3) The medical uses of the atom are now being effectively explored and evaluated through the several radiological societies and the Society for Nuclear Medicine.

We feel that it would be quite proper, at this time, to discontinue this committee. It could well be re-appointed at some future date should the necessity arise.

**Medical Procurement Advisory Committee.**—This committee held no meetings during the past year since no problems arose which called for a meeting and no references were made by officers or committees of the Society which required consideration.

However, various members of the Committee have served in various capacities in medical procurement. Dr. Grover C. Penberthy continues as Chairman of the Voluntary Advisory Committee to the Selective Service System and your Chairman as Medical Advisor to the Director of Selection Service for Michigan.

**Special Committee to Meet with Michigan Department of Social Welfare.**—As in the past five years, this Committee has formed the major part of a larger Advisory Committee under the chairmanship of Milton Shaw, M.D. We have met at the call of the Director of the Welfare Commission a total of five (5) times since September, 1955. Various problems were studied and recommendations made, including reappraisal of the Totally Disabled and Aid to Dependent Children Categories; the adaption of "actual cost" medical care in all counties; possibility of dental care for A.D.C. cases; and many other important matters.

The Social Welfare Commission has again thanked this Committee for its valuable contributions and respectfully requests a continuation of the same in the future.

**Committee on Blood Banks.**—There have been no specific meetings of the Committee on Blood Banks of the Michigan State Medical Society since 1955. However, since that time members of the Committee have been working on the Constitution and By-laws of the Michigan Association of Blood Banks and we have become incorporated in the State of Michigan. We are now in the midst of a membership drive and the response is very favorable.

The annual meeting of the Michigan Association of Blood Banks was held jointly with the meeting of the Michigan Pathology Society in East Lansing on May 5, 1956. At that time the officers elected were: R. L. Mainwaring, M.D., president; E. R. Jennings, M.D., vice president; and Joseph A. Kasper, M.D., secretary-treasurer. The Association felt that since it is young and growing, the officers who presided last year should be kept over for the coming year.

During this year, we plan on having a scientific program on November 3, at which time papers will be presented discussing technical and administrative aspects of blood banking.

**Hospital Relations Committee.**—The activity of the Hospital Relations Committee for 1956 was confined to a joint meeting with a committee of the Michigan Hospital Association. Considered discussion centered around the principles adopted in 1953 by official bodies of the American Medical Association, and the American Hospital Association seemed to adequately cover the relationship between the Michigan State Medical Society and the Michigan Hospital Association. These principles are as follows:

1. The general purpose of hospitals and physicians is to aid each other in the delivery of the best possible medical care to patients. To attain such a purpose requires full co-operation among medical staffs, governing boards and administrative heads of hospitals. One important method of attaining this objective is that duly designated representatives of the medical staff shall have

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free and direct access to the governing board with due consideration to the position of the administrator as chief executive officer of the hospital. The various methods by which the medical staff may have access to the hospital governing board follow. These methods are not listed in the order of their desirability, and there may be other acceptable liaison plans developed depending upon local conditions.

- (a) The executive committee of the medical staff and a committee of the governing board with the hospital administrator can serve as a joint committee.
- (b) Representatives of the medical staff can serve as members of the medical staff committee of the governing board with the hospital administrator.
- (c) Representatives elected by the medical staff can attend meetings of the hospital governing board.
- (d) Members of the medical staff can be members of the hospital governing board.

2. The professional evaluation of chiefs of service and members of the medical staff should be the responsibility of the medical profession. The method of selection of these individuals must be subject to local arrangement and local conditions. In any such arrangement, however, the principle of the freedom of the staff to make recommendations, subject to the approval of the hospital governing board, should be recognized.

3. The medical profession and the hospitals recognize that certain special services, such as anesthesiology, pathology, radiology and physical medicine, are integral parts of the practice of medicine and of the services necessary for hospital patients. Physicians in these fields should have the professional status of other members of the medical staff. Chiefs in these specialties must assume also the administrative responsibilities and relationships customarily associated with such positions.

4. THE RIGHT OF AN INDIVIDUAL TO DEVELOP THE TERMS OF HIS SERVICES ON THE BASIS OF LOCAL CONDITIONS AND NEEDS IS RECOGNIZED, BUT SUCH CONTRACTUAL ARRANGEMENTS SHOULD IN ALL CASES ENSURE (A) THE POLICY OF PROFESSIONAL INCENTIVE FOR THE PHYSICIAN, AND (B) PROGRESSIVE DEVELOPMENT OF THE HOSPITAL DEPARTMENTS INVOLVED, IN ORDER THAT INCREASINGLY IMPROVED SERVICES TO PATIENTS MAY BE RENDERED. MOREOVER, A PHYSICIAN SHALL NOT DISPOSE OF HIS PROFESSIONAL ATTAINMENTS OR SERVICES TO ANY HOSPITAL, LAY BODY, ORGANIZATION, GROUP, OR INDIVIDUAL, BY WHATEVER NAME CALLED, OR HOWEVER ORGANIZED, UNDER TERMS OR CONDITIONS WHICH PERMIT EXPLOITATION OF THE PATIENT, THE HOSPITAL OR THE PHYSICIAN.

5. The chief of a hospital department may have access to financial information regarding his department.

6. It is desirable that means should be provided at local, state and national levels for review of problems of individual hospital-physician relationship by organized medical and hospital groups.

*Committee to Study Closed Panel Practice.*—The Society year, 1955-1956, has been a lean one for the Closed Panel Practice Committee as they only have had an opportunity for one meeting in January, 1956.

At this meeting, some of the aims planned were discussed and assignments were given to various members to investigate as fully as possible the various Closed Panel Plans now in vogue throughout the country; principally, the Health Insurance Plans of Greater New York, The Permanente Plan in California, the various Palo Alto Plans, and The Ross-Loos Plan in Los Angeles, as well as the plans of individual physicians, and various union groups.

One of the members propounded as a basic premise the following questions: What does the public want? What does the medical profession want? What do the labor unions want? We will try to answer these questions.

The Chairman, on a recent trip to California, investigated most of the California Plans, and is going to report these at the ensuing meeting, which we hope will be held shortly.

*Committee on Study of Prevention of Highway Accidents.*—The Committee had three meetings this past year, plus considerable work by many Committee members outside the time of meetings.

*School Bus Driver Examination:* The Committee has prepared an outline of a physical examination for school bus drivers, who at the present time do not need anything more than a chauffeur's license to qualify. This outline will be distributed to schools by the State Department of Public Instruction as a suggested outline for school boards to require their school bus driver applicants to pass.

*High School Driver Training Legislation:* The Committee actively supported the resolution adopted by the MSMS House of Delegates last September urging the Legislature to adopt a driver training law, and had contacts with the Governor and legislators on this subject. Some of the Committee's arguments received editorial comment in the *Detroit Free Press*. Michigan now has probably the most outstanding driver training legislation in the country. At the Traffic Safety Conference held in Chicago in May, this program received more comment than anything else Michigan has done traffic-wise.

*Highway Safety on Extramural Programs:* Dr. John Sheldon, Chairman of the Extramural Postgraduate Education Committee, met with the Traffic Committee for a mutual discussion of this problem. It was moved that two two-man teams be provided for possible use in the extramural programs this fall to discuss different aspects of the treatment of highway accidents.

*Local Medical Society Traffic Committees:* Several local medical societies have formed traffic safety committees after this suggestion was made by the MSMS Committee by way of the Secretary's Letter.

*MSMS Activities at AMA Level:* The following resolution was initiated by the Committee and introduced by the Michigan Delegation at the December meeting of the AMA and was passed unanimously: "That the American Medical Association through its House of Delegates strongly urges the President of the United States to request legislation from Congress authorizing the appointment of a national body to approve and regulate safety standards of automobile construction." This resolution was referred by the AMA to the President's Committee on Traffic Safety.

The Chairman of the Committee introduced a resolution by way of the MSMS House of Delegates and the Michigan delegation to the AMA calling on the AMA to form a committee for the study of highway accidents. This resolution was passed and such a committee has been formed and was responsible for a fine traffic safety scientific exhibit at the June AMA meeting in Chicago, as well as for a half day program at one of the general sessions. Dr. Claire Straith, member of the MSMS Committee, was responsible for one of the exhibits.

A letter was drafted by the Committee and sent in the name of MSMS to Mr. Harlow Curtice, Chairman of the President's Committee on Highway Safety, urging that the AMA be made a member of the Advisory Council to the President's Committee. This has been done.

The Chairman of the Committee, as a member of Michigan's AMA delegation, appeared before the AMA reference committee considering both of the above mentioned resolutions last November, and also before the reference committee considering a Georgia State Medical Society's resolution on traffic safety at the June meeting of the AMA. At his suggestion the reference committee amended the latter resolution to suggest that some time soon the AMA call a nationwide conference to consider the medical problems of highway safety, with emphasis being placed on urging individual state medical societies to initiate traffic safety committees. As a result of this the Chairman of the AMA Traffic Study Committee has asked the MSMS Committee to prepare a tentative program for such a meeting.

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Regional Traffic Safety Conference in Chicago: This was called by the President's Committee on Traffic Safety. The MSMS Chairman attended by appointment of MSMS President Jones. Three other of the 153 members from Michigan were physicians, representing the Michigan Committee on Trauma. The Conference was called to focus attention on the value of state and local safety councils, with Minnesota's experience as a state and Muskegon's as a small city as examples. The Michigan delegation elected a temporary Action Committee on Traffic Safety to call upon the Governor, of which the Chairman is a member.

Local Medical Society Participation in Safety Councils: The Committee urges that county societies should be alerted to cooperate with local safety councils, and should help to initiate them in areas where they do not exist.

The Chairman would like to thank the very busy members of this Committee for their untiring efforts and wonderful cooperation. No MSMS Chairman could have a better committee!

*Committee on Study of Basic Science Act.*—The 1955 Legislature of Michigan amended the Basic Science Law in such a way that the Michigan Board of Basic Science Examiners was granted more discretionary powers, and the law itself considerably liberalized. Briefly, the changes in the law were as follows:

1. The passing grade of the Basic Science Examination was raised from 70 to 75 per cent.
2. Substituted the phrase "substantially equal to" for the previous wording of "as comprehensive and exhaustive" as a means of comparing the Basic Science examinations of other states with that of Michigan.
3. Placed upon the applicant the responsibility of producing a copy of his examination before the licensing board of another state, and a certified copy of answers if available.
4. The Board was given the power to accept examinations given by any legally constituted licensing board in ANY state or territory, in ANY of the healing arts, if comparable to the examination of the Michigan Board, for the purpose of granting waivers in lieu of the Michigan examination.

The passage of the 1955 amendment had certain effects that were immediately apparent as shown by the table below:

### *Certified by Waiver*

|  |     |
|--|-----|
| January 1, 1953 to November 1, 1954..... | 116 |
| November 1, 1954 to May 1, 1956.....     | 335 |

It should be noted that previous to 1954, waiver was possible with only one state because of the Attorney General's opinion. In 1954 waiver was possible with eleven states (after amendments by the 1954 Legislature) and in 1955 seventeen states were acceptable for waiver after amendment.

The number of applicants who desired certification in Michigan continues to show some increase. As more applicants are certified by waiver the number of examinations would naturally decrease. This is indicated by the fact that only 130 applicants wrote the examination in February, 1956. For the previous three years the numbers writing the examinations were as follows:

|           |     |
|-----------|-----|
| 1953..... | 600 |
| 1954..... | 657 |
| 1955..... | 640 |

Two hundred and thirty-five applicants wrote the examinations May 11 and 12, 1956.

According to the figures of the Basic Science Board of Examiners, the rate of failures is fairly constant at approximately 15 to 18 per cent, and the same Board also reports that certificates are granted to applicants from the various healing arts as follows:

|  | Per Cent |
|--|----------|
| Board of Registration in Medicine..... | 86 to 87 |
| Osteopathic Board of Registration..... | 12 to 13 |
| Chiropractic Board .....               | 2        |

In general the status of Basic Science in Michigan as compared to other states may be summarized as follows:

1. Michigan has waiver with seventeen of the twenty-one states having Basic Science Laws. The four states in which waiver is not possible give examinations which are not "substantially equal" and therefore unacceptable to the Michigan Board. For example, the Florida examinations were considered as very elemental. No questions in bio-chemistry were given, the questions being equivalent to high school inorganic chemistry.

2. The Basic Science Law has not been repealed recently in any state.

3. The numbers of states having Basic Science Laws remains constant at twenty-one.

4. There have been some changes in the basic science laws enacted in other states, for example, Washington and Oregon, who formerly examined in four subjects, have now added a fifth.

### COMMENTS

The Basic Science Law in Michigan seems to be serving the purpose for which it was enacted, that of keeping out substandard healers. If there is any misgiving regarding osteopaths, it should be borne in mind that the educational standards of the osteopathic schools of medicine have been on the up-grade and their recent graduates should be well able to pass the basic science examination. The same is not true of the chiropractors. High school education only is required of basic science applicants.

The present laws permit the granting of waivers on examinations given by ANY of the legally constituted boards of licensure in the healing arts from ANY state or territory. It includes osteopathic and chiropractic boards along with state boards of medical licensure. There is always the potential danger that the granting of waivers on such a wide basis may eventually tend to lower the standards of medical practice in Michigan. This is a possible trend that we can only observe at this time.

Some state boards refuse to send examination questions for evaluation, even medical boards. This may be a source of difficulty for some applicants. In the past, even the Michigan Board of Basic Science Examiners could not procure examinations from some states for use in comparative evaluation.

There have been expressed some misapprehensions that the present status of basic science in Michigan acted to penalize our own graduates of medicine within the state. However, we have been informed that most Michigan medical students take the basic science examination at the end of their second year in medicine, when basic sciences are fresh in mind, and are encountering very little, if any, difficulty.

There is one far-reaching possibility that basic science legislation, standing in the way of substandard practitioners, may have a salutary effect in raising the standards of practice in healing arts outside of medicine.

### CONCLUSIONS

1. The effect of the 1955 amendments by the Legislature has been to grant increased discretionary powers to the Basic Science Board of Examiners, and to liberalize the law considerably.

2. Michigan has waiver privileges with seventeen of the twenty-one basic science states.

3. The Basic Science Law has been amended in 1953, 1954 and 1955. It would seem inadvisable to seek further changes in the law at present as it is apparently serving the purpose for which it was enacted, that of keeping out substandard healers.

4. We believe the Committee on the Basic Science Law should be continued to review any proposed changes to this law and to review the status each year for the House of Delegates.

*Committee to Study Periodic Health Examinations in Hospitals*—There has been no meeting of this Committee in 1956. Statistics compiled in 1955 indicated there

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were eight hospitals in Michigan conducting these examinations for persons other than their own employees.

County societies are requested to report to MSMS how these examinations are managed in their areas.

**Joint Committee with State Bar of Michigan.**—This Committee was appointed by The Council to formulate an interprofessional code with the State Bar of Michigan and has had two meetings.

Several other interprofessional codes or articles of agreement were discussed and investigated, namely from Wisconsin, Cincinnati, and Minnesota. The advantages and disadvantages of these various plans were discussed, and ideas from both the legal and medical members of the Committee were added to the discussion. The State Bar representatives on the Committee were strongly of the opinion that they had been directed to help draft standards only, and not to devise punitive measures.

A motion was made at the last meeting that a subcommittee composed of one representative from each of the two professional groups be appointed to study the various plans now being used elsewhere with regard to medical testimony and to prepare in draft form a statement of principles to be submitted to the State of Michigan; this draft to be submitted to each member of this joint Committee for consideration, suggestions, and improvement. This motion was carried.

The Committee, Dr. MacMillan and Mr. Vandever, was appointed and will report later.

**Mediation, Ethics and Grievance Committee.**—This Committee has had two meetings, the first of which dealt with consideration of the problems involved. The second meeting concerned discussion of the definition of the terms "mediation," "ethics" and "grievance."

A third meeting was held, when a summation of the problems and definite recommendations were formulated for presentation to the House of Delegates in a form suitable for incorporation in the By-Laws.

*A recommendation on this subject follows.*

**Liaison Committee with State Executive Office.**—This committee thought that its function should be to discuss with the Governor matters in certain fields of common interest in those areas of public welfare in which both the Governor's office and the Michigan State Medical Society have particular interest—not in those instances where problems lie within the purview of only one or the other.

With this in mind, the Committee recommended that a letter be dispatched to the Governor stating that we are glad to meet with him or his representatives for discussion of mutual problems.

**Study Committee on Fee Schedules for Michigan Medical Service.**—The Fee Schedule Committee met five times and carried out the two assignments given it by the 1955 House of Delegates of the MSMS. The first assignment was to draft a fee schedule for a \$6000 Michigan Medical Service family income service contract which the Ford Motor Company and the UAW-CIO had agreed to have and had requested of Michigan Medical Service. The second assignment was to develop an ethical and legal method for division of the scheduled fee of Michigan Medical Service between physicians.

The questionnaires received from every member for suggested fees and the questionnaires from the following groups, General-Board and non-Board, Specialists-Board and non-Board and Specialty Societies were gone over in great detail, each item being considered individually. The Committee attempted to fix fair and reasonable fees both for the participating doctors and the policy holders. The fee schedule as developed was submitted to The Council of the MSMS for its consideration.

The following motion was adopted by the Committee (with three dissenting votes—Doctors Hansen, Osius, and Wellman) re MSMS House of Delegates resolution on division of the scheduled fees of Michigan Medical Service and submitted to The Council of the MSMS:

"Whenever more than one doctor of medicine actively and personally participates in any medical

treatment of or surgical procedure on a patient for which a single fee is payable by Michigan Medical Service, the doctor in charge of such care shall specify in writing the portion of such fee which has been earned by the assisting or consulting doctors and inform Michigan Medical Service of the amount thereof.

"Thereupon, the Michigan Medical Service shall be authorized to allocate and pay the respective portion of the scheduled fee directly to the participating doctors in accordance with such direction."

The Committee wishes to express its appreciation of the great amount of work done by many of the members of the Michigan Medical Service Staff and for their cooperation and advice. It would also be remiss if it did not thank Mr. William J. Burns and Miss Helen Schulte of the MSMS Headquarters Staff for their very able assistance.

**Committee on VA Hometown Medical Care Contract.**—The Michigan State Medical Society was notified by Dr. W. S. Middleton, Chief Medical Director of V.A., that the home town medical care program for veterans would be terminated July 1, 1957.

The Council recommended that the Michigan State Medical Society send a delegation consisting of Blue Shield Director John W. Castellucci, representatives of the Michigan State Medical Society, interested Congressmen and representatives of Veterans' Organizations to Washington to discuss with Mr. H. V. Higley and Dr. Middleton the benefits of retaining the present contracts with the intermediary (Blue Shield) in Michigan.

**Health and Accident Insurance Policy Control Committee.**—Four meetings of the Committee on Health and Accident Insurance Policy Control were held this year.

Request from a component society for comparison of the Michigan Policy with that of the Texas Medical Association was discussed and the information forwarded.

A new card for solicitation was developed for use by Provident's Michigan representative, Mr. Richard M. McDermott, who is now visiting MSMS members throughout the State to explain the MSMS Health and Accident Insurance Program and to offer his services.

Statistics: 544 claims have been received from November 15, 1953, to June 15, 1956: two claims have been paid for the full 104 weeks (\$7,700 plus in each case); four accidental death claims have been paid, each approximating \$3,500. Full information and statistics available to this Committee will be made public to all MSMS members, through an article in THE JOURNAL.

In view of the increasing number of potential prospects in Michigan for the MSMS Health and Accident Insurance Program, this Committee recommended that Provident augment the splendid efforts of Mr. McDermott by instituting a concerted drive during the balance of 1956.

## Litigation and Legislation

1. Legal action of Wm. A. Kopprasch, M.D., of Allegan against MSMS, the Allegan County Medical Society, et al. This effort of Dr. Kopprasch to gain entrance into the Allegan Health Center of Allegan has been in the Circuit Court since January 13, 1955. The motion to particularize the plaintiff's bill of complaint was argued by legal counsel in Allegan on April 26; subsequently, the judge ruled that Dr. Kopprasch's motion was indefinite, and hazy and that the plaintiff has been instructed to amend the complaint or his pleading will be stricken. A second motion was filed by MSMS for the same purpose, and it was granted.

2. Legislation in respect to cultists was discussed in detail by The Council at its July, 1956, Session. These discussions were transmitted to county society officers and MSMS Delegates and heard throughout the summer at Councilor District Conferences. The subject has been thoroughly aired to aid decision by the House of Delegates.

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### Matters Referred to The Council by 1955 House of Delegates

1. Last September, the House of Delegates recommended that component county societies of Michigan conduct polls of their memberships on the question of Old Age & Survivors Insurance Program "to determine as accurately as possible the consensus of the medical profession in this state, and that the result of his poll be presented to the House of Delegates at the 1956 Session."

As of July 1, returns on this poll were received as follows: Bay-Arenac-Iosco, Delta-Schoolcraft, Genesee, Gogebic, Grand Traverse-Leelanau-Benzie, Hillsdale, Houghton-Baraga-Keweenaw, Ingham, Ionia-Montcalm, Kalamazoo, Lapeer, Lenawee, Livingston, Marquette-Alger, Mason, Menominee, Muskegon, Northern Michigan, Shiawassee, Van Buren, Washtenaw, and Wayne.

2. Resolution recommending that a committee be appointed to investigate the workings of the California Cancer Commission and others now functioning, and to make recommendations concerning the advisability of organizing a Michigan Cancer Commission or to utilize existing committees for the purpose of investigating, evaluating, and exposing all so-called cancer cures that are presently known or may appear in the State of Michigan.

Pursuant to this resolution, The Council appointed a special Committee on Study of Cancer Quackery (Wm. A. Hyland, M.D., Chairman; E. T. Thieme, M.D., J. M. Wellman, M.D., and R. C. Hildreth, M.D.). This MSMS Committee recommended that it be integrated as a Committee on Cancer Quackery into the structure of the Michigan Cancer Coordinating Committee (representing the six Michigan agencies primarily interested in cancer control). This recommendation was approved by the MCCC which appointed the same personnel plus Don A. Johnson of Flint as its Subcommittee on Cancer Quackery. The Committee studied the California experience. Incidentally, only Michigan and California have Committees on Cancer Quackery.

The recommendations of the Committee on Cancer Quackery are:

(a) Each county medical society appoint a cancer committee to concern itself among other matters with the subject of Cancer Quackery; those county societies which do have a cancer committee should be urged to enlarge its scope to include a thorough knowledge of quackery and in cooperation with the national offices and local unit of the American Cancer Society to keep the members of the medical society informed of the current progress in cancer diagnosis and treatment. Further, to fully inform the public through radio and newspaper articles, talks and discussions, dissemination of literature and by word of mouth, concerning the danger of departing from the type and form of treatment recommended by the physicians and hospitals in their area.

(b) To further protect the patient, especially the advanced cancer patient, this Committee recommends that each hospital cancer committee review all advanced cancer patients, through the usual methods with the attending physician or physicians, who in turn will make known to the patient or family the opinion of the group as to the type and stage of the disease and what to expect—and to detail every safeguard at his or their command against the wiles and enchantment of the charlatan and his emissaries.

The weakness of the profession through which the quacks, take advantage is the very integrity of physicians—especially in advanced cancer—the admission by the profession that the cancer is advanced and there is very little to be done for the patient—this leaves the patient and family high and dry—therefore making it easy for the unscrupulous quack to enter the picture at a price, with his generous promises, at a moment when the patient and family are at a low ebb mentally due to the shocking information.

The patient who has a good chance for recovery is

not of too great concern as to the possibility of falling into the hands of the quack. It is the advanced or terminal patient. However, the medical profession has much more to offer than the quack and in an honest manner—by a thorough explanation and not charging any great fee.

In such cases, we can institute chemo-therapy on a research and high moral basis—patients will gladly cooperate with the thought in mind of helping others and possibly themselves, especially when they realize the cost to them or their family is small. The quack cannot compete with this type of treatment or procedure.

Much has and is being done in research by the National Cancer Institute, American Cancer Society and others in chemo-therapy; the aid of these institutions is readily available as also the drugs they might recommend. Such help as this by the immediate medical resources who and which are known to the patient is the bulwark against the fraudulent practitioner.

(c) The Committee further recommends an editorial in THE JOURNAL of the Michigan State Medical Society on Quackery in Cancer.

(d) On the bi-monthly cancer page in the Michigan State Medical Society Journal, the Committee recommends frequent reference to quackery.

(e) The Committee recommends that county medical societies release to the daily and weekly papers in their area approved medical material on cancer quackery.

(f) The Committee recommends that this same material and knowledge be made available for local radio and television stations.

Further, the Committee suggests the Garland talk, "The Pursuit of the Unorthodox," presented to the American Cancer Society recently, be reprinted and distributed to all members of the Michigan State Medical Society if we are granted permission by the Medical Director of the American Cancer Society.

3. Resolution re possible optometric legislation. The Council has been alerted to the inherent dangers of such proposals, if introduced into the Michigan Legislature, and is ready to inform legislators as to the intent of such legislation, in order that the rights of the patient to complete care and examination by the licensed physician will not be jeopardized. A copy of this resolution was forwarded to the AMA Board of Trustees which answered, through Secretary George F. Lull, M.D., that the matter was being referred to the AMA Law Department which is at the present time making a study of optometric legislation.

4. Resolution re pollution of inland waterways. The Council urged the Michigan Department of Conservation to investigate this situation and take proper steps to eliminate any problems which may be disclosed. The Water Resources Commission of the State of Michigan, at its January 26 meeting, received the resolution and directed Milton P. Adams, its Executive Secretary, to acknowledge its receipt and express thanks for the MSMS offer of cooperation.

5. Resolution re screening of foreign interns. This recommendation was presented to the members of the Michigan State Board of Registration in Medicine. Secretary E. C. Swanson, M.D., replied December 19, 1955, that "the matter has been taken care of."

6. Resolution re periodic health examinations by hospital staffs. Copies of this resolution were sent to the Chairmen of medical staffs of accredited hospitals in Michigan, to members of the Michigan Industrial Medical Association, and to the secretaries of all county medical societies with an accompanying letter of explanation. The Committee on Study of Periodic Health Examinations in Hospitals (O. B. McGillicuddy, M.D., Chairman, L. J. Bailey, M.D., V. N. Slee, M.D., and E. P. Vary, M.D.) followed through on the instruction of the 1955 House of Delegates and found there were eight hospitals in Michigan conducting these examinations for other than their own employees.

7. Resolution re presentation of scroll to R. L. Novy, M.D., longtime President of Michigan Medical Service.

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This was accomplished at a special luncheon arranged March 8 during the Michigan Clinical Institute.

8. Resolution re Salk vaccine propaganda was referred to the Michigan Delegation to the AMA House of Delegates. Resolutions from other states implemented this on the national level.

9. Resolution re fee for examination of mentally ill. Copies of this resolution were referred to each component county society with the request that it ask the probate judge or judges in its area to adjust the fee; also this request was the basis of a communication to the Michigan Probate Judges Association.

10. Resolution re Mediation in Michigan Medical Service cases. Copies of this resolution were sent to Michigan Medical Service and noted in the Secretary's Letter addressed to officers of component county societies.

11. Resolution re Study of Surgical Fees (Michigan Medical Service). This also was referred to the Study Committee on Fee Schedules (MMS) which accomplished a thorough study of all the fees in the various surgical specialties (see Annual Report of this Committee).

### Recommendations

1. That the 1 per cent collection credit now granted to county medical societies be eliminated, inasmuch as all membership billing will be performed by the Michigan State Medical Society, and will relieve component society secretaries of this detail work.

2. That The Council be authorized to send MSMS representatives to Washington, D.C., in 1957 on the occasion of the Annual Michigan Day.

3. That contributions to the Beaumont Memorial Restoration Fund—by every individual MSMS member—be urgently recommended by the 1956 House of Delegates, and that a special letter campaign be conducted during the months of October, November, and December, 1956. Thus, every MSMS member will be given the opportunity to contribute with pride to the Beaumont Memorial—which will represent for generations the best type of public relations for the entire medical profession in this state.

Should any part of the debt owed the Michigan State Medical Society be extant as of December 31, 1956, this sum should be wiped off the MSMS books and listed permanently as the Society's contribution to the Beaumont Memorial, in accordance with Resolution adopted by the 1955 House of Delegates.

Further, that the following recommendation of the Beaumont Memorial Committee be given serious and favorable consideration by the House of Delegates recognizing that sustained effort is vital, that a Beaumont Memorial Foundation be created immediately to further the purposes and continuing needs of the Beaumont shrine at Mackinac Island, that every MSMS member be notified that he is not only eligible to join at an annual membership fee to be determined, but that he be invited and urged to join.

4. That the House of Delegates instruct The Council whether or not the Uniform Fee Schedule for Governmental Agencies should be restudied and revised, before necessary reprinting.

5. That the recommendations of the Committee on Mediation, Ethics, and Grievance be given serious consideration, at this Session, by the House of Delegates.

6. That medical men become increasingly active in civic affairs, assuming the opportunities and obligations of their standing as leading citizens, to the end that pub-

lic opinion generally is continued favorable to a maintenance of the present high standards of public health and medical education and service. This best is accomplished on the local level through active membership by doctors of medicine in chambers of commerce, health councils, and other reputable community and civic organizations.

7. That members of the MSMS House of Delegates, as the natural leaders in their medical areas, express pride before their confreres in the excellent MSMS health and accident insurance program (Provident Life and Accident Insurance Company) so that during the ensuing Society year, a substantial majority of members is enrolled in this protective device.

8. That the following amendments to the Constitution and By-Laws be considered by the 1956 House of Delegates:

(a) Amend the Constitution in Article X, Sections 1, 2 and 3, so that the Vice Speaker of the House of Delegates is made a member of The Council and of its Executive Committee, with power to vote. (Also amend the By-Laws, Chapter 11, Section 10.)

(b) Amend the By-Laws in Chapter 8, Section 10-d, to specify that AMA Delegates and Alternate Delegates shall take office on January 1 following their election in September.

(c) Amend the By-Laws (Chapter 11, Section 4) so that all county medical societies in a Councilor District first shall be contacted for approval of proposed appointment of a Councilor by the President, in case of resignation of a Councilor.

9. That the House of Delegates eliminate the present assessment and authorize in lieu thereof an increase in dues adequate for the maintenance of our modern Society program and to insure reserves necessary to meet a major emergency.

Respectfully submitted,

### THE COUNCIL

|   |  |
|---|--|
| D. Bruce Wiley, M.D.,<br><i>Chairman</i>  | B. M. Harris, M.D.<br>William Bromme, M.D.   |
| W. B. Harm, M.D.,<br><i>Vice Chairman</i>   | J. E. Livesay, M.D.,<br><i>Speaker</i>   |
| A. E. Schiller, M.D.<br>O. B. McGillicuddy, M.D.<br>G. W. Slagle, M.D.<br>Ralph W. Shook, M.D.<br>J. D. Miller, M.D.<br>H. H. Hiscock, M.D.<br>H. B. Zemmer, M.D.<br>L. C. Harvie, M.D.<br>G. B. Saltonstall, M.D.<br>W. S. Stinson, M.D.<br>W. M. LeFevre, M.D.<br>B. T. Montgomery, M.D.<br>T. P. Wickliffe, M.D. | K. H. Johnson, M.D.,<br><i>Vice Speaker</i><br>W. S. Jones, M.D.,<br><i>President</i><br>Arch Walls, M.D.,<br><i>President-Elect</i><br>L. Fernald Foster, M.D.,<br><i>Secretary</i><br>W. A. Hyland, M.D.,<br><i>Treasurer</i><br>R. H. Baker, M.D.,<br><i>Immediate Past President</i> |

### ANNUAL REPORT OF THE PUBLIC RELATIONS COMMITTEE—1955-1956

With several years of intensive effort to build on, MSMS Public Relations activities were expanded during the past year, and an awareness of PR penetrated even more deeply into the many facets of MSMS' program. Beyond heading up PR operations for the Michigan medical profession on the state and national levels, your Public Relations Committee placed additional emphasis upon aiding the promotion of planned PR efforts among county medical societies and their individual members.

Keynotes for the new year of effective PR program-

JMSMS

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ming were presented at the three-day PR Seminar in Detroit last January, when representatives of most county societies convened for a concentrated educational program directed by a "faculty" experienced in the problems threatening the private practice of medicine today, the policies of medical organization, and the successful methods needed to reach the immediate and long range goals of the medical profession. Expansion of the former one-day conference to a three-day seminar was received enthusiastically and proved to be a wise step in promoting continued interest among county societies.

Intra-professional understanding of the aims, policies, and achievements of MSMS is the cornerstone for successful public relations. To increase such understanding, a new brochure entitled "Progress-Because Doctors Work Together" was published in January under direction of the Public Relations Committee. This booklet, first distributed at the PR Seminar, was placed in the hands of every member of MSMS. Each new member receives a copy of this orientation handbook upon joining the Society. The brochure explains the history, structure, operations and advantages of MSMS, and encourages participation in medical organization.

### Medical Education Week a Success

The most intensive single campaign of the year with PR value was Michigan participation in the first nationwide observance of a Medical Education Week in April, spearheaded by MSMS with strong collaboration from the State's two medical schools and a Detroit Citizen's Committee composed of civic and industrial leaders. Additional strong support of this campaign was given by the Woman's Auxiliary. Among all the states taking part, Michigan assumed a position of leadership. The campaign plan adopted by MSMS for Medical Education Week and the evidence of our success have been compiled into a kit by the National Foundation for Medical Education for distribution to the nation's eighty-two medical schools. This kit will serve as a guide for planning the observance of Medical Education Week in 1957.

Adopting a positive approach, MSMS used this campaign to show how the medical profession in Michigan has sought through the years to (1) increase the number of M.D.'s, (2) improve the distribution of medical service, (3) enlarge our medical schools without sacrificing quality, and (4) attract graduates and practitioners from other states. A graphic presentation developed to tell the basic story found its way into almost every daily and weekly newspaper in Michigan, and attracted widespread editorial comment.

Other Medical Education Week activities worthy of mention are: the Governor's proclamation, with a tape recording of the Governor reading his words distributed to 100 radio stations; three-quarter page display advertisements by MSMS in five major Sunday newspapers and one metropolitan weekly paper; two MSMS news releases to 400 Michigan newspapers, both widely used; one release from the Detroit field office to 431 community publications; spot announcements to all Michigan's radio and television stations; open house at Wayne State University College of Medicine attended by 500 carefully selected community leaders; programs and spot announcements carried by sixty radio stations; special television programs over four metropolitan TV stations; appearances before service clubs in several major cities; various community activities before civic groups, including the showing of MSMS movies.

The Woman's Auxiliary received first place honors in the national "80 dimes campaign" conducted in connection with Medical Education Week.

### Co-operation with County Societies

As a stimulus to local PR planning, MSMS Officers and staff members met with various county society PR chairmen and officers, PR committees, and other leaders of county societies. Special meetings on PR programs and problems were conducted with county society lead-

ers in Wayne, Branch, Monroe, Hillsdale, Lenawee and Macomb counties. At such meetings the MSMS guidebook for local PR effort, "Winning Friends for Medicine," in its revised form, was used as the basis for planning a well-rounded program. A series of special public relations conferences were held with leaders of county medical societies in the Upper Peninsula in July, when top MSMS Officers and PR representatives visited that area.

Of primary importance were the appearances of President W. S. Jones, M.D., before almost every county medical society in the State with an illustrated talk on the progress, program, and benefits of MSMS. A PR representative accompanied Dr. Jones on each of his visits and conferred informally with society officers to offer MSMS help in meeting local PR needs.

### Display Advertisements Scheduled

A bold new departure was introduced in April at a time when voluntary prepaid medical service as typified by Michigan Medical Service (Blue Shield) was the target of a rash of misleading news articles instigated by groups who for many years have been associated with a long-term campaign for federal health insurance. Under PR Committee supervision, with approval of The Council, eye-catching advertisements were prepared by MSMS giving the facts about Blue Shield. The first advertisement appeared in five of the largest Sunday newspapers and the State's second-largest weekday newspaper. Other display advertisements in the series have been prepared for use at the discretion of The Council.

Looking to sustained PR activity in the future, the groundwork has been laid for establishing a Public Relations Library. The advices of professional librarians have been used to catalogue and codify the great mass of PR materials and tools accumulated through the past decade. The new library at MSMS headquarters in Lansing is seen as a major resource in the efficient operation of our PR program in years to come.

With another look to the future, educational activities among medical students, interns, and residents, in social and economic aspects of the private practice of medicine, were stepped up during the year. Although not under the direct jurisdiction of this Committee, these activities received full co-operation. Social, economic and PR topics were presented to senior students at both of the medical schools in Michigan. In the interest of better understanding of medical organization and a greater PR consciousness, enlargement of this program is under active consideration.

### "Good Citizenship" Stressed

With 1956 being a crucial election year in which M.D.'s, their families and associates should accept their full responsibility, "good citizenship" activities were inaugurated early in the pre-election period. The importance of being properly registered and casting a vote in both the primary and general elections is being stressed, along with the necessity for choosing qualified candidates. All members of MSMS, its Woman's Auxiliary, and the Michigan State Medical Assistants Society are being urged to do their duty as "good citizens." An informal "committee of 400," selected from among members who have shown above-average interest in governmental affairs in the past, serve as the action group in the "good citizenship" efforts.

In its various informational and educational work during the past year, MSMS again has had excellent co-operation from, and great success with, all media of mass communication in the State.

Working through county societies, the impact via radio and television has been unusual. Much of the radio and television programming has been handled through the PR Field Secretary in Detroit. Seventeen powerful radio stations have blanketed the State with transcribed health and medical broadcasts supplied by AMA through MSMS to local societies. In most instances these programs have been presented daily. All

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but three stations have used more than one thirteen-week series, with many stations using more than five, and one station using as many as eighteen series during the year.

From a script prepared by the MSMS PR Department, the Saginaw County Medical Society presented a series of "live" fifteen minute programs weekly for thirteen weeks.

### Popular Radio Shows

MSMS is now assisting Wayne County Medical Society in a weekly radio show broadcast Sunday evenings over WJBK. The "Tell Me, Doctor" radio series continues to be heard over two Michigan stations. This MSMS program has been used continuously for more than eight years by radio stations WHFB in Benton Harbor and WKZO in Kalamazoo, with the same pharmacies as sponsors throughout the period. WKZO now writes fresh scripts from material supplied by MSMS. Each script is screened by a MSMS representative.

In addition to the special Medical Education Week telecasts already mentioned, weekly series of film shows over WPAG-TV, Ann Arbor, inaugurated in 1953, continued throughout this year. Material for these telecasts is provided by MSMS in co-operation with the Washtenaw County Medical Society. Over WKAR-TV, East Lansing, MSMS co-sponsored a weekly medical program from September to June. Alternate sponsors were the Ingham County Medical Society and the Michigan Health Department. MSMS also co-operated with the Michigan Health Council in its weekly TV show over WKAR-TV.

The MSMS film library, available for use by county societies in presenting local telecasts, was enlarged this spring by the addition of five kinescope recordings dealing with popular medical subjects and prepared by the University of Michigan Medical School.

Medical and health news on a variety of topics prepared during the year by MSMS were readily accepted by newspapers and the newswire services. A new medical column was inaugurated in "The Michigan Farmer," most widely read farm journal in the State, through arrangements made by your PR Committee. Educational material was presented to thousands of additional persons through specially prepared exhibits sponsored by MSMS at the 1956 Michigan Rural Health Conference in Kalamazoo, the 10th Annual Michigan Clinical Institute in Detroit, the Michigan State Pharmaceutical Association Convention in Grand Rapids, the MSMS 90th Annual Session, and the 1955 Michigan State Fair. The Michigan Diabetes Society was invited to share space in the State Fair exhibit, a partnership which was highly successful.

MSMS also exhibited at the first Flint Vocational Fair for high school students, and supplied quantities of material on medical education and medical associates careers for a number of "vocational days" held in high schools throughout the State.

Although no new movies have been released by MSMS during the past year, the filming of a motion picture on epilepsy has been completed and earlier productions are still timely and have great audience appeal. During 1955-56 "Lucky Junior," "To Save Your Life" and "In Planning Your Career" have been shown some 250 times before audiences totaling approximately 20,000. The demand for these films continues.

MSMS' collaboration year to year with close to 200 statewide and national organizations and agencies interested in the field of health continues to have PR aspects of immeasurable value. This liaison is carried on with both governmental and voluntary groups, and each year new areas of co-operation are discovered and utilized.

Close bonds are maintained with such closely related organizations as Michigan Medical Service, the Michigan Health Council, the State Health Department, Michigan Crippled Children Commission, Michigan Cancer Coordinating Committee and a number of similar organizations with which MSMS has maintained a cordial work-

ing relationship. Stronger bonds were formed with the Adult Education Association, Michigan State Pharmaceutical Association, and several organizations in the field of mental health. The relationship with the State Board of Registration in Medicine was strengthened and revitalized. MSMS worked closely with that agency and its new administration in several important projects, and devised a plan for creating goodwill among new medical licensees by providing attractive printed copies of the Hippocratic Oath through the offices of the State Board.

### A Look to the Future

Although MSMS has made great strides since inaugurating an intensive PR program several years ago, this Committee feels that there can be no letdown. On the contrary, we believe we must search for new avenues for promoting good public relations, and try to expand those methods which have proven successful in the past. The ultimate goal is to preserve medical freedom and the private practice of medicine so the people of Michigan may continue to benefit from medical progress and high standards of health care.

In everyday government, industry, and community life there are a growing number of elements antagonistic to the private practice of medicine. Even so-called "conservative" community leaders and civic groups continue to propose ideas and projects which, if carried to the ultimate, would greatly curtail the freedom of the medical profession to the detriment of the people it serves. Many of these proposals are made on the basis of misinformation and cloudy reasoning. Other individuals and organizations already are openly committed to policies which would restrict private medicine. Medical organization and the medical profession can meet and defeat these continuing threats only by a sustained presentation of the truth through every available channel.

Respectfully submitted,  
C. ALLEN PAYNE, M.D., *Chairman*  
R. W. TEED, M.D., *Vice Chairman*  
S. E. ANDREWS, M.D.  
H. G. BACON, JR., M.D.  
J. F. BEER, M.D.  
H. G. BENJAMIN, M.D.  
F. C. BRACE, M.D.  
M. W. BUCKBOROUGH, M.D.  
J. W. BUNTING, M.D.  
M. O. CANTOR, M.D.  
E. M. CHANDLER, M.D.  
S. E. CHAPIN, M.D.  
H. D. DYKHUIZEN, M.D.  
H. B. FENECH, M.D.  
E. H. FENTON, M.D.  
R. A. FRARY, M.D.  
W. G. GAMBLE, JR., M.D.  
L. E. GRATE, M.D.  
A. B. GWINN, M.D.  
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L. T. HENDERSON, M.D.  
W. J. HERRINGTON, M.D.  
E. J. HILL, M.D.  
J. W. JACOBOWITZ, M.D.  
K. H. JOHNSON, M.D.  
R. C. KINGSWOOD, M.D.  
J. L. LEACH, M.D.  
CLAYTON LEWIS, JR., M.D.  
E. C. LONG, M.D.  
F. E. LUDWIG, M.D.  
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J. M. MARKLEY, M.D.  
O. B. MCGILLICUDDY, M.D.  
H. J. MEIER, M.D.  
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E. S. OLDHAM, M.D.  
E. S. PARMENTER, M.D.  
R. C. PECKHAM, M.D.  
J. R. PEDDEN, M.D.

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G. N. PETROFF, M.D.  
A. C. PFEIFER, M.D.  
W. Z. RUNDLES, M.D.  
SYDNEY SCHER, M.D.  
A. E. SCHILLER, M.D.  
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C. L. WESTON, M.D.  
WAYNE L. WHITAKER, Ph.D.  
V. M. ZERBI, M.D.  
L. FERNALD FOSTER, M.D., *Advisor*  
L. W. HULL, M.D., *Advisor*  
B. T. MONTGOMERY, M.D., *Advisor*  
T. P. WICKLIFFE, M.D., *Advisor*

### ANNUAL REPORT OF THE ETHICS COMMITTEE—1955-1956

Once again we report a marked inactivity which may be attributed to several things: (a) the component societies are having indoctrination meetings for new members which gets them off on the right foot; (b) local ethics committees are accepting their responsibility more than in the past and doing their own "laundry" at home; (c) business is generally so good that there is no occasion for attempts at shadowy practices nor a desire to take on more work than comes honestly.

All three of the cases reviewed by this Committee ended up under heading (b) above, two automatically after a slight hint that the problem was local. The third one required a special meeting where, after considerable argument, the decision of the local society was reversed by the majority of those present.

We are proud to be members of a society that behaves generally so well.

Respectfully submitted,  
H. W. PORTER, M.D., *Chairman*  
W. L. HARRIGAN, M.D.  
R. J. HUBBELL, M.D.  
F. H. LINDENFELD, M.D.  
E. A. OAKES, M.D.  
A. H. PRICE, M.D.  
E. A. OSIUS, M.D.  
W. F. STRONG, M.D.  
C. E. UMPHREY, M.D.  
M. R. WEED, M.D.  
J. JOSEPH HERBERT, LL.B.

### ANNUAL REPORT OF ADVISORY COMMITTEE TO MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY—1955-1956

The Medical Assistants Society Advisory Committee held two meetings during the year 1956.

The initial meeting was held at the Durant Hotel, Flint, on April 15, 1956, at which time the completed program of the MSMAS Convention in Detroit on September 26 and 27, 1956, was discussed and approved. The Committee also noted with approval a health and accident insurance group plan for the MSMAS. The Advisory Committee expressed a favorable opinion of the organizational meeting of the American Association of Medical Assistants held on November 5 and 6, 1955, in Kansas City, Kansas. Fifteen states were represented at this meeting at which time tentative Constitution and By-Laws were drawn up. The first annual meeting of this new organization is to be in October, 1956, at Milwaukee, Wisconsin.

Noteworthy was the one-day meeting of medical assistants of the Upper Peninsula on June 23, 1956, at Sault Ste. Marie, Michigan. The meeting was held for the purpose of forming a Component Society of Upper Peninsula Medical Assistants and the attendance was gratifying.

Relative to assisting medical physicians in securing more skillful office personnel the MSMAS, for the first time, presented a scholarship for a one-year course for Medical Assistants at the Highland Park Junior College.

Membership in the MSMAS now totals 715 with a total of fifteen Component Societies as of May 15, 1956.

The energetic Medical Assistants printed two lengthy Bulletins, a News letter and a post-Convention Bulletin which contained presidential reports and beneficial news for each member during 1956.

The second meeting of the Advisory Committee, held on June 3, 1956, at 606 Townsend Street, Lansing, was held primarily because of the requirements of the MSMAS constitution.

Great praise should be given the MSMAS for their attitude in making theirs one of the outstanding groups in the nation. They have set an excellent example for future medical assistants societies and have improved each year they have been in existence in number and ability. Their officers are of the highest calibre and are to be complimented on their administrative accomplishments.

Respectfully submitted,  
F. J. BUSCH, M.D., *Chairman*  
RALPH W. SHOOK, M.D.  
R. W. POMEROY, M.D.  
E. R. SHERRIN, M.D.  
OTTO VAN DER VELDE, M.D.  
J. E. WEBBER, M.D.

### ANNUAL REPORT OF ADVISORY COMMITTEE TO WOMAN'S AUXILIARY—1955-1956

There were no meetings of this Committee during the year. Several discussions of matters relating to the activities of the Auxiliary occurred between the Chairman and the President of the Auxiliary. Two matters of importance were referred directly to the Executive Committee of The Council.

The members of the Committee are aware of the fine work of the Auxiliary and refer the Delegates to the Annual Report of the President to be presented at the opening session of the House.

Respectfully submitted,  
J. E. LIVESAY, M.D., *Chairman*  
A. B. ALDRICH, M.D.  
W. J. BUTLER, M.D.  
D. F. SCOTT, M.D.  
W. L. SHERMAN, M.D.

### ANNUAL REPORT OF THE GERIATRICS COMMITTEE—1955-1956

The Geriatrics Committee held two meetings this year, one in Detroit and the other in Ann Arbor with a good representation each time. Several subcommittee meetings were held relative to health insurance plans for the older person; conference planning for the Geriatric meeting in Ann Arbor; diabetes exhibit at the State Fair; improving standards for nursing homes through the co-operation of the County Bureaus of Social Aid, Board of Health and Association of Approved Nursing Homes. Several of our members have filled speaking engagements throughout the State before lay audiences talking on various gerontological subjects.

The original plan of having another conference on aging for physicians during the winter was discarded when it was learned that the 9th Annual Conference on Aging to be held in Ann Arbor during the summer was to have as its theme "Health for the Aging," medical and social services. It was thought that these two conferences could best be combined, and would be jointly co-sponsored by the Michigan State Medical Society and the Departments of Postgraduate Medicine and Gerontology at the University. The State Society, through a program subcommittee, took an active part in the planning of this conference and several of its members participated in the workshops and clinics.

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Several excellent live clinical presentations were held at the University Hospital and were well attended.

During the next year it is hoped that the May issue of the Michigan State Medical Society Journal will be devoted entirely to geriatric problems. Conferences are also planned with the State Department of Health for improving the standards in nursing homes throughout the State.

Respectfully submitted,

A. HAZEN PRICE, M.D., *Chairman*  
F. C. SWARTZ, M. D.  
C. H. ADAMS, M.D.  
R. M. ATHAY, M.D.  
F. W. BASKE, M.D.  
H. B. BENNETT, M.D.  
J. R. BRINK, M.D.  
E. F. CRIPPEN, M.D.  
R. E. DUSTIN, M.D.  
G. S. FISHER, M.D.  
P. C. GITTINS, M.D.  
W. D. HARRELSON, M.D.  
E. J. KULINSKI, M.D.  
J. J. LIGHTBODY, M.D.  
HERBERT ROSENBAUM, M.D.  
J. M. RYAN, M.D.  
L. F. SEGAR, M.D.  
C. W. SELLERS, M.D.  
G. C. THOSTESON, M.D.  
S. C. WIERSMA, M.D.  
C. S. WILSON, M.D.  
H. W. WUGHTER, M.D.  
W. M. LEFERVE, M.D., *Advisor*

### ANNUAL REPORT OF MATERNAL HEALTH COMMITTEE—1955-1956

The Maternal Health Committee continues in the sixth year of its study of maternal deaths in the State of Michigan. Several interesting and vital things have occurred in the past year.

1. At the national level, two meetings have occurred with representatives from the states presently participating in state surveys in an effort to bring about uniformity and agreement in scope, definitions, aims and results, so that comparisons of the state surveys can be made and put together in one large national picture. Michigan has had representatives at these meetings and our activities have been surveyed by the National AMA Committee, and we have been reported in detail in the American Medical Association Journal. The observations our Committee published in the Michigan State Medical Society Journal, February, 1955, have been referred to by authors on similar studies in several states.

2. As of October, 1955, the State Health Department was fortunate in obtaining the services of Dr. Charles Behney as Consultant to the Department in Maternal and Child Welfare. He provides a distinct impetus to the Committee's activities and is again furnishing that liaison between the Committee and the local physicians throughout the state.

3. In November, 1955, under the combined auspices of the State Maternal Health Committee and the Michigan Society of Obstetricians and Gynecologists, a meeting was held in Grand Rapids, at which time Dr. John McKelvey of Minnesota was our guest speaker. By means of short presentations by our own members in Michigan, namely, Dr. L. Paul Ralph, Dr. Tommy N. Evans and Dr. Mary Lou Byrd, Dr. McKelvey was able to make comparisons between Michigan and Minnesota and exchange ideas and experiences which we are sure are beneficial both to the studies in Michigan and Minnesota.

4. In February, 1956, the Oakland County Medical Society activated its Maternal Health Committee to review maternal deaths at regular monthly meetings. The attendance at these meetings has been approximate-

ly twenty (20) physicians in Oakland County each month.

The entire Maternal Health Committee had a meeting in February, 1956. Meanwhile, the numerous subcommittees are constantly at work. Presently, in June, 1956, the Subcommittee on Publications is reviewing and attempting to bring about a résumé of the first four years, and by September this same Committee expects to have the evaluation and observations available for publication of the first five years.

Within a few days of the writing of this report, the entire Committee is planning to meet and we have as our guests at that time, Dr. James F. Donnelly, Chairman of the Maternal Health Committee of North Carolina, who will exchange with us ideas and experiences and Mr. J. Joseph Herbert, Legal Counsel for the MSMS. At this same meeting we are expecting a report from a subcommittee with respect to the establishment of a registry of maternal tissues, to be housed and utilized for teaching purposes.

Respectfully submitted,

P. E. SUTTON, M.D., *Chairman*  
FRANCIS A. JONES, JR., M.D.  
F. W. BALD, M.D.  
C. A. BEHNEY, M.D.  
C. M. BELL, M.D.  
H. R. BRUKARDT, M.D.  
G. B. CORNELIUSON, M.D.  
A. L. FOLEY, M.D.  
MARGARET S. HERSEY, M.D.  
E. S. HOFFMAN, M.D.  
W. C. LAMBERT, M.D.  
H. W. LONGYEAR, M.D.  
A. G. McCUAIG, M.D.  
N. F. MILLER, M.D.  
H. A. OTT, M.D.  
C. F. SHELTON, M.D.  
C. S. STEVENSON, M.D.  
D. W. THORUP, M.D.  
C. E. TOSHACH, M.D.  
KATHRYN D. WEBURG, M.D.  
H. R. WILLIAMS, M.D.  
VIOLA G. BREKKE, M.D.  
MARY LOU BYRD, M.D.

#### Addendum

1. The Maternal Health Committee in collaboration with the Michigan Department of Health presented an exhibit on maternal and neonatal mortality to the medical institute in Detroit in the spring, and to the Upper Peninsula Medical Society on June 22 and 23.
2. The Committee with the Department of Health prepared a specimen obstetric record form which complies with the requirements of the Department of Health for licensure and provides all data necessary for a satisfactory study of maternal deaths.

### ANNUAL REPORT OF THE LEGISLATIVE COMMITTEE—1955-1956

Every year it becomes more and more evident that constant legislative alertness and diligent, concerted activity in the legislative sphere by MSMS is a responsibility it cannot lightly dispatch. The experience of the 1956 legislative session emphasizes the acuteness of this responsibility to the medical profession and coincidentally to the well-being of the citizens of Michigan.

The chiropractors made their perennial attempts to enlarge their scope of practice into medical fields; a single department administration of health agencies of the state received much attention; and efforts of pressure groups to discredit and destroy Blue Shield and Blue Cross broke into the open.

At last count (since at this writing the Legislature is still convened in Special Session) there have been introduced in the 1956 session 801 bills; of these 93 have required the attention—in greater or lesser degree—of MSMS. Because the members of the Legislature were able to get accurate and immediate information

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from MSMS regarding this maze of health proposals much improvement was made in the existing laws. Also it must be noted that because of the efforts of MSMS, and other allied organizations also dedicated to improving health standards in Michigan, passage of legislation deleterious to the high standards already established in Michigan was prevented.

Justifiably MSMS can take satisfaction in the knowledge that it was instrumental in preventing the passage of these proposals which would have:

- permitted chiropractors to practice medicine, chiropractic, osteopathy, psychiatry, in effect anything they wished, because of a cleverly worded change in the definition of chiropractic (H. B. 181, failed to be reported from House Committee); a companion measure would have allowed their licensing board to increase its power over individual members through a change in their code of ethics adoption procedure (H. B. 273, failed to be reported from House Committee);

- instituted a single department administrator over most of the state's health agencies, including the Mental Health Commission, the Hospital Survey and Construction Department, the Tuberculosis Sanatorium Commission, the Department of Health, and at one stage the Crippled Children Commission, with no promise of its workability (H. B. 102 and S. B. 1044, one defeated on the House floor and the other in Senate Committee);

- allowed influx of substandard physicians into Michigan by removing powers of the Board of Registration in Medicine to maintain "quality control" of Michigan licensure and reciprocity (H. B. 8, failed to be reported from Senate Committee);

- instituted annual registration of M.D.'s prematurely without an accurate estimate of costs to be incurred by the Board of Registration in Medicine or the amount of annual registration fee necessary (H. B. 219, failed to be reported from House Committee);

- directed a Legislative Committee to "study methods and procedures whereby an osteopathic college of medicine could be established" within Michigan, presumably as a state institution (Senate Resolution No. 19, failed to be reported from Senate Committee);

- threatened the quality of medical and hospital care for Michigan crippled children and afflicted children, and opened the door not only to osteopaths, but to chiropractors and substandard hospitals as well, by way of an amendment attached to a routine appropriation bill, which amendment was removed in the final hours of the regular session.

By the same token MSMS can take credit for the fact that it helped sponsor and support some creditable health legislation which:

- established regional diagnostic centers for mentally ill and required diagnosis of patient after commitment by the Probate Court but prior to final admittance to institution (H. B. 21);

- transferred the licensing of nursing homes from the Social Welfare Commission to the State Health Commissioner and revised operational procedures (H. B. 382);

- provided for establishment of community health clinics (formerly child guidance center) on local levels (S. B. 1311);

- increased old age assistance benefit ceilings from \$80 to \$90 per month for hospitalization (S. B. 1109);

- established Wayne University as a State University (H. B. 287);

- made initial and continuing appropriations to the University of Michigan for construction of a Medical Science Building, a Mental Research Building and a Children's Pediatric Unit (S. B. 1338 and S. B. 1339).

MSMS also took a keen interest in national legislation and working closely with the AMA contributed to many successes in the Congress. In May a delegation from the state society met in Washington with many congressional and other governmental leaders.

Space does not permit here a lengthy introspection

into every phase of action on every piece of legislation of interest to MSMS in the 1956 session of the Legislature; many proposals were annual irritants, such as the chiropractors' attempts to legislate themselves into practices for which they are neither trained nor qualified; many were the products of the changing times, such as House Bill 243 which would regulate the handling and use of radioactive materials in industry; none were lightly dealt with by MSMS legislative personnel.

In the final analysis the individual M.D. is the most important man in the entire legislative effort of MSMS. This is an election year. If every M.D. in Michigan will remember that he is also a citizen of his community; if he will support the legislative candidate who has the greatest understanding of the problems of health and is dedicated to the maintenance of the progress already made; if every M.D. will then make himself available to his legislator for advice and counsel; only then will Michigan be able to boast of the best health program of any state in the nation.

To all of our colleagues who have in the past year contributed so generously of their time, counsel and cooperation we offer our heartfelt thanks. To them must go the honors for the successes credited to the Legislative Committee.

Respectfully submitted,

L. A. DROLETT, M.D., *Chairman*  
O. B. MCGILLICUDDY, M.D., *Vice Chairman*  
A. B. ALDRICH, M.D.  
WILLIAM BROMME, M.D.  
G. V. CONOVER, M.D.  
J. C. ELLIOTT, M.D.  
O. K. ENGELKE, M.D.  
N. J. HERSHEY, M.D.  
M. H. MARKS, M.D.  
P. T. MULLIGAN, M.D.  
J. S. ROZAN, M.D.  
E. C. SWANSON, M.D.  
H. A. TOWSLEY, M.D.  
R. V. WALKER, M.D.  
ARCH WALLS, M.D.  
D. BRUCE WILEY, M.D.

### ANNUAL REPORT OF MENTAL HEALTH COMMITTEE—1955-1956

During the year ending May, 1956, the Committee on Mental Health held three general meetings. Two new subcommittees were appointed.

Members participated in the following meetings:

1. Second Annual Conference on Mental Health, American Medical Association at Chicago.
2. Preventive Medicine Committee Meeting of Michigan State Medical Society.
3. Meeting of Michigan Association for Retarded Children arranged by the Michigan Welfare League.
4. Meetings with Michigan Society of Neurology and Psychiatry.
5. Meeting with Executive Committee of the Michigan State Medical Society Council concerning the Minnesota Plan for Expert Testimony.

A compilation of the results of the Epileptic Survey was made by the Subcommittee on Convulsive Disorder with the help of Mr. Raymond Dennerll, Executive Director of Michigan Epilepsy Center. Since there was only a five per cent return of the questionnaires, it was decided that the Mental Health Committee should continue its interest in the entire problem of epilepsy, especially in regard to acquainting doctors of medicine with the diagnosis and treatment of epilepsy; and that a second circularization of medical doctors in Michigan should be considered.

The Attorney General's Opinion on Psychotherapy was carefully considered and discussed. The Mental Health Committee feels strongly that psychotherapy is a medi-

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cal treatment, and that Opinion No. 2359 should be revoked.

A number of mental health bills which had been introduced in the State Legislature were studied by the Committee. Its opinions with respect to the proposed legislation were thereafter submitted for the information of the Legislative Committee.

The Mental Health Committee agreed with the American Medical Association's approval of the series of letters "Milestones to Marriage" which might be suitable for distribution to high school seniors. This project is being sponsored by the Woman's Auxiliary of the American Medical Association.

The Chairman wishes to thank the members of the Committee on Mental Health for their interest and support, and it is our hope that the activities of the Mental Health Committee have been of some assistance to the Michigan State Medical Society.

Respectfully submitted,

I. A. LA CORE, M.D., *Chairman*  
Z. S. BOHN, M.D.  
W. E. CLARK, M.D.  
F. P. CURRIER, M.D.  
J. M. DORSEY, M.D.  
T. J. HELDT, M.D.  
L. E. HIMLER, M.D.  
M. H. HOFFMANN, M.D.  
R. F. KERNKAMP, M.D.  
M. H. MARKS, M.D.  
P. A. MARTIN, M.D.  
F. O. MEISTER, M.D.  
C. J. MUMBY, M.D.  
W. H. OBENAUF, M.D.  
R. W. WAGGONER, M.D.  
E. M. WILLIAMSON, M.D.  
H. B. ZEMMER, M.D.

### ANNUAL REPORT OF THE SCIENTIFIC RADIO COMMITTEE—1955-1956

During the year forty scientific radio programs were prepared and presented by members of the Michigan State Medical Society and the faculties of the University of Michigan Medical School and the Wayne State University College of Medicine. These broadcasts went out weekly over radio stations WUOM, WPAG, WBRM, WDET, WKAR, WLDL, WMDM and WFUM.

The following titles are of the subjects discussed: The Hygiene of Pregnancy, Management of Labor, Anesthetics, Care of the Newborn, The Baby's First Year, Feeding in the First 5 Years, The Cerebral Palsied Child, Muscular Dystrophy, Obesity—How to Reduce, Arthritis, Arthritis Research, Physical Medicine—Rehabilitation of Arthritis, Backache, What Can We Do About Polio Today, Rehabilitation of the Polio Patients, Juvenile Diabetes, Adult Diabetes, Congenital Heart Disease, Rheumatic Heart Disease, Acquired Heart Disease, Living with Your Heart Disease, Accident Prevention in Childhood, Living with the Atom Bomb, Burns, What Abdominal Pain Means, Your Responsibility in Case of Accident, Skin Cancer, Cancer of the Female Generative Organs, Gastrointestinal Cancer, Lung Cancer, Cancer of the Prostate, Multiple Sclerosis, What Mental Health Means to Me, Hearing, Headaches, The Importance of Tuberculosis, Treatment of Tuberculosis, Seasonal Allergy, Summer Skin Complaints, Adolescent Problems—Sex Education.

Insofar as is possible the programs were developed to coincide with the activities of the National and State Health agencies, i.e. Cancer Month, Heart Month, et cetera. Taped recordings of each of the above programs have been made available through the Michigan State Medical Society for use by county medical societies or physicians who wish to either use them directly or to give similar talks to lay audiences in their own communities. At the meeting of this Committee on December 15, 1955, the following recommendations were made:

1. To broaden the distribution of these tape recordings to additional stations in the state.
2. It is planned to expand health education programs to the public schools in some 40 counties in the state. These schools are now receiving the Michigan Radio Classroom from station WUOM of the University of Michigan. These programs should be available in the fall of 1956.

Respectfully submitted,

H. A. TOWSLEY, M.D., *Chairman*  
C. B. BEEMAN, M.D.  
J. H. BUELL, M.D.  
W. L. FOSTER, M.D.  
C. E. LEMEN, M.D.  
G. H. SCOTT, Ph.D.  
R. W. TEED, M.D.  
K. W. TOOTHAKER, M.D.  
E. C. VONDER HEIDE, M.D.  
J. M. SHELDON, M.D.

### ANNUAL REPORT OF POSTGRADUATE MEDICAL EDUCATION COMMITTEE—1955-1956

The Committee met twice during the year, on January 12 and May 26.

Members of the Committee suggested subjects for the postgraduate medical education program: These subjects included (a) newer drugs and their effectiveness, (b) the doctor's responsibility in prevention of home accidents, especially in children, (c) asphyxia and anoxia in the newborn, and (d) rehabilitation. In connection with the last mentioned subject, the Committee on Study of Prevention of Highway Accidents, of which Dr. John R. Rodger is Chairman, suggested that a panel of two of the maxillo-facial surgeons and a neurosurgeon give a program at one center, and at another center the program be given by an orthopedic surgeon and a general surgeon interested particularly in abdominal bleeding.

All these subjects were thought to be timely and suitable, and the local members of the Committee were authorized to make the necessary arrangements to include them in the program whenever speakers on these subjects were available.

The recommendation that two speakers only be sent to a center for a program has been carried out and has proved to be very satisfactory.

Dr. W. S. Stinson, Councilor and Chairman for the 10th District, reported that Bay City enthusiastically requested the continuation of an extramural teaching center there.

The Chairman reported on the extramural program in the various teaching centers:

The subjects presented during the year were:

#### Fall Program

Recent advances in allergy  
Diseases of extra-hepatic biliary tract  
Hypertension  
Myocardial infarction  
Newer drugs of proven and potential value  
Peripheral vascular disease  
Some medical and surgical aspects of endocrine disease  
Surgery of peptic ulcer  
Systemic disease in relation to oral disease  
Treatment of liver disease  
Treatment of peptic ulcer  
Treatment of thyrotoxicosis

#### Spring Program

The medical and surgical management of heart disease  
Medical economics and medico-legal aspects of medicine  
Pathological physiology of the liver  
Management of facial injuries  
Neurological emergencies  
The treatment of thyrotoxicosis  
Surgery in the aged  
Urological problems in infancy and childhood

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## Attendance—Extramural Program

| Center           | Fall<br>1955 | Spring<br>1956 | 1955-56 |
|------------------|--------------|----------------|---------|
| Alpena           | 15           | 18             | 20      |
| Battle Creek     | 65           | —              | 65      |
| Bay City         | 26           | 26             | 39      |
| Cadillac         | —            | 33             | 33      |
| Flint            | 120          | 37             | 131     |
| Jackson          | 73           | 52             | 78      |
| Lansing          | 80           | 70             | 83      |
| Muskegon         | 68           | 75             | 88      |
| Port Huron       | 33           | 31             | 37      |
| Traverse City    | 36           | —              | 36      |
| Upper Peninsula  |              |                |         |
| Escanaba         | 18           | 16             | 22      |
| Houghton-Calumet | 21           | 18             | 25      |
| Iron Mountain    | 16           | 19             | 20      |
| Ironwood         | 20           | 16             | 25      |
| Marquette        | 26           | 21             | 30      |
| Menominee        | 24           | 21             | 26      |
| Sault Ste. Marie | 26           | 31             | 39      |
|                  | 667          | 484            | 797     |

The Michigan Clinical Institute was held in Detroit on March 7-8-9. The program was well attended, the total registration being 2,475.

A list of intramural activities offered by Wayne State University College of Medicine is as follows:

## Wayne State University College of Medicine

| Name of Course                      | Attendance |
|-------------------------------------|------------|
| Advanced Hematology                 | 3          |
| Basic Ophthalmology                 | 11         |
| Beginning Hematology                | 7          |
| Cellular Physiology                 | 1          |
| Blood                               | 3          |
| Conference on Anesthesiology        | 22         |
| Conference on Nutrition             | 15         |
| Conference on Traumatic Surgery     | 225        |
| Gastroenterology                    | 3          |
| General Endocrinology               | 3          |
| Gynecologic Pathology               | 21         |
| Medical Conference                  | 5          |
| Microbiology Seminar                | 2          |
| Parasitology and Medical Enterology | 1          |
| Pathology of the Heart              | 6          |
| Pathology of Neoplasms              | 6          |
| Pathology of Parasitic Diseases     | 5          |
| Physiological Chemistry Seminar     | 1          |
| Physiology and Pharmacology Seminar | 6          |
| Psychoanalytic Psychiatry           | 2          |
| Psychosomatic Conference            | 2          |
| Regional Anatomy                    |            |
| Thorax, Abdomen and Pelvis          | 32         |
| Head and Neck                       | 2          |
| Back and Extremities                | 8          |
| Seminar in Dermatology              | 5          |
| Surgery Seminar                     | 23         |
| Special Topics                      | 1          |
| Symposium on Blood                  | 200        |
|                                     | 620        |

The following is an explanatory note by Arthur H. Smith, Director of Graduate Medical Education at Wayne State University:

"As you probably know these same courses are attended by our graduate students in the basic medical sciences and residents in hospitals who are in our graduate program. The enrollment figures given, however, are just for postgraduate doctors."

## University of Michigan Medical School

| Intramural Courses                          | Attendance |
|---|------------|
| Anatomy                                     | 27         |
| Basic Science                               | 30         |
| Clinical Exercises for Practitioners        | 9          |
| Clinical Internal Medicine                  | 53         |
| Diagnostic Radiology                        | 15         |
| Diseases of Blood and Blood-forming Organs  | 21         |
| Diseases of the Gastrointestinal Tract      | 25         |
| Diseases of the Heart                       | 29         |
| Electrocardiographic Diagnosis              | 60         |
| Foreign Physicians                          | 12         |
| Interns, Assistant Residents and Residents  | 358        |
| Metabolism and Endocrinology                | 26         |
| Obstetrics and Gynecology                   | 42         |
| Ophthalmology                               | 146        |
| Otolaryngology                              | 28         |
| Pediatrics                                  | 33         |
| Radio-active Isotopes, Clinical Use of      | 25         |
| Recent Advances in Therapeutics             | 38         |
| Surgical Pathology Slides and Miscellaneous | 14         |
|   | 991        |

The following named physicians participated in the extramural postgraduate teaching program: Leonard

Alexander, M.D., Paul S. Barker, M.D., William C. Baum, M.D., William H. Beierwaltes, M.D., Robert J. Bolt, M.D., Paul Campbell, M.D., Robert Crowley, M.D., Byrne M. Daly, M.D., Reed O. Dingman, M.D., Samuel W. Donaldson, M.D., Stefan S. Fajans, M.D., C. Thomas Flotte, M.D., Clifford W. Gurney, M.D., Harper K. Helms, M.D., Paul E. Hodgson, M.D., Sibley W. Hoobler, M.D., Lyle F. Jacobson, M.D., Yoshikazu Morita, M.D., M. H. Seevers, M.D., John M. Sheldon, M.D., E. T. Thieme, M.D., Joseph L. Whelan, M.D., and Irving Young, M.D.

Upon recommendation of the Committee on Postgraduate Medical Education, the Michigan Foundation for Medical and Health Education granted certificates of Associate Fellowship in Postgraduate Medical Education to thirty-eight physicians and certificates of Fellowship to twenty-seven physicians.

The progress that is being made in the field of colored television for teaching purposes, including its future possibilities as a means of education for physicians in practice, was presented to the Committee.

The subcommittee to study audio-digest and clinic programs on tapes for distribution to the Michigan State Medical Society, consisting of Drs. M. A. Darling, R. M. McKean and E. G. Upjohn, reported on this subject in detail. In view of the multiplicity of factors involved, including places for storage and distribution of such tapes, it is recommended that these studies be continued and further report be made to the Committee as a whole at the next meeting.

The report by Mr. William J. Burns, Executive Director, MSMS, on the potential attendance in the extramural centers was most informative. Interestingly enough, it demonstrated that of the potential number between 60 and 75 per cent were attending our various programs. Mr. Burns followed a novel method of arriving at the potential attendance, in that he used maps relative to shopping centers in Michigan which would seemingly serve the doctors of a similar community in postgraduate medical education.

Respectfully submitted,

J. M. SHELDON, M.D., *Chairman*  
E. I. CARR, M.D.  
D. A. CAMERON, M.D.  
B. R. CORBUS, M.D.  
M. A. DARLING, M.D.  
A. C. FURSTENBERG, M.D.  
J. R. HEIDENREICH, M.D.  
D. H. KAUMP, M.D.  
R. M. MCKEAN, M.D.  
D. W. MCLEAN, M.D.  
J. M. ROBB, M.D.  
G. H. SCOTT, Ph.D.  
E. F. SLADEK, M.D.  
H. A. TOWSLEY, M.D.  
E. GIFFORD UPJOHN, M.D.  
F. A. WEISER, M.D.  
H. H. CUMMINGS, M.D.

## ANNUAL REPORT OF PREVENTIVE MEDICINE COMMITTEE—1955-1956

The following is a brief review of the activities of several of the Advisory Committees during the past year.

The Cancer Control Committee has integrated its projects and work with the Michigan Cancer Coordinating Committee which has set up several "basics": (1) a summary of recommendations; (2) the annual Michigan Cancer Conference; (3) a study of cancer quackery; (4) bi-monthly cancer pages in THE JOURNAL of the Michigan State Medical Society and a special cancer number of our JOURNAL; (5) talks before professional and lay groups and distribution of the Cancer Manual. In addition, the Committee sponsored an exhibit on cancer quackery and a lecture by O. H. Wangenstein, M.D., at the 1956 Michigan Clinical Institute, and participated actively in the Third National Cancer Conference held in Detroit during June, 1956.

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The Maternal Health Committee continues with its survey of maternal deaths, its accomplishments so far having received widespread notice and favorable comment.

The Geriatrics Committee has been very active in looking into the matter of prepayment health insurance plans for the aged; in setting up an exhibit on diabetes at the Michigan State Fair; in sponsoring a conference on gerontology at Ann Arbor; and in stimulating the interest of doctors of various communities towards improving the standards of nursing homes by providing medical supervision and inspection. The problem of service to the older age groups was discussed at several meetings with representatives of labor and management.

The Scientific Radio Committee is doing an outstanding job letting others speak for it to the tune of some 40 lectures on pertinent subjects.

The Postgraduate Medical Education Committee arranged a program that was favorably received throughout the State by an increasing number of doctors.

The Rheumatic Fever Control Committee revised and added to its series of Desk Reference Cards; sponsored a TV show in Bay City; arranged for bicillin to be made available for rheumatic fever prophylaxis; and participated in a program at Jackson for the annual meeting of the Michigan Society for Crippled Children and Adults.

The above list covers some of the outstanding activities of the Advisory Committees. The individual committee reports appearing in this handbook present in detail the telling effort that is being made by the medical profession in the interest of better public health.

The Committee is again grateful to our State Health Commissioner Dr. A. E. Heustis for his active participation in our deliberations and his helpful suggestions.

Respectfully submitted,  
W. S. REVENO, M.D., *Chairman*  
I. A. LACORE, M.D.  
B. E. BRUSH, M.D.  
A. C. CURTIS, M.D.  
S. T. HARRIS, M.D.  
R. M. HEAVENRICH, M.D.  
A. E. HEUSTIS, M.D.  
W. A. HYLAND, M.D.  
O. J. JOHNSON, M.D.  
A. H. PRICE, M.D.  
J. M. SHELDON, M.D.  
P. E. SUTTON, M.D.  
J. W. TOWEY, M.D.  
H. A. TOWSLEY, M.D.

### ANNUAL REPORT OF VENEREAL DISEASE CONTROL COMMITTEE—1955-1956

Dr. C. A. Smith, Medical Director, Chief, Venereal Disease Program of Special Health Services, Department of Health, Education and Welfare, reported that the venereal disease rate in Michigan was falling. In some states the venereal disease rate has increased as much as 700 per cent (due to an increase in gonorrhea). Michigan's reported venereal disease rate is only up 1 per cent, but reporting VD is still poorly done in Michigan. It was the consensus of the Committee that everything possible should be done to make the blank used for reporting venereal disease as simple as possible so that physicians could be better encouraged to report all venereal disease which they treat.

Dr. John Cowan reported on the migrant labor problem in the State of Michigan. A survey done in 1949-50 showed the major health problems among these people to be tuberculosis, venereal disease and dysentery. In surveys made in Saginaw County area, a rate of 19 cases of tuberculosis per 1000 x-rayed was found. Similar surveys of Saginaw residents the same year showed a rate of 0.7 active cases per 1000 x-rayed. In venereal disease, 439 migrants were given blood tests. Of these, 64 had positive serologic tests for syphilis. This was a positive STS rate of 144 per 1000 tested as com-

pared to the Saginaw County average rate of 10 per 1000 tested at the time of the survey. During 1955 re-screening of migratory workers in the Saginaw-Huron-Tuscola and Bay County areas was done. The hours the clinics were open were 6:00 p.m. until midnight which made these examinations convenient to the employers but definitely inconvenient to the workers. The Department of Health was not satisfied with the results obtained in the 1955 survey and it was suggested (Dr. Cowan) that some venereal disease pamphlets be translated into Spanish dialect for a better dissemination of information regarding this disease to the migratory workers. The Department of Health again plans to survey this group in 1956 and other groups of migratory workers working in co-operation with the Michigan Sugar Beet Industry and Fruit Growers' Association.

Since tuberculosis and venereal diseases are both high in this group and hence pose a problem of dissemination of these diseases to Michigan's fixed population, the Venereal Disease Control Committee recommended and passed the following motion:

"That the Venereal Disease Control Committee of the Michigan State Medical Society approves and urges the continuation of the migrant labor screening program for the year 1956 with utilization of all available services of the United States Public Health Service to screen at the source from which the workers come to correlate the end results with these findings as a basis for future study of migrant health problems in Michigan."

Dr. Cowan reported on the results of a selective mass blood testing program in 1955 when specimens were obtained by house to house canvassing and by utilizing those in small industry. The Department took 19,347 bloods, 915 positive and/or doubtful, 4.7 per cent doubtful, (non-white 7.1 per cent, white 1.6 per cent) 38 per cent with positive tests and 25 per cent with doubtful tests needed treatment. A larger survey will be made in Detroit during the coming year, testing persons sixteen years of age and over. Figures indicate that positive tests increase with age. It is estimated that 80 per cent are in the late, latent stage of the disease. Discussion brought out the fact that in 1955 gonorrhea appeared higher than in any year since 1947, and it was the feeling of the Committee that perhaps only 20 per cent of gonorrhea in Michigan is reported.

After considerable discussion regarding new serologic tests, the diagnosis of the following motion was made and passed:

"That the Venereal Disease Control Committee of the Michigan State Medical Society recommends to the Michigan Department of Health that it seriously consider establishing TPCF tests in the State Health Department Laboratories on request."

Dr. L. W. Shaffer reported on the high incidence of venereal disease in teen-age high school groups in the Detroit area and a "Family Living" program has been instituted. It was reported that this program has been a major factor in the 40 per cent reduction in the venereal disease rate in the school in which it was instituted. The courses are given by teachers and the program is sponsored by the Mayor's Youth Committee and the Detroit Board of Education. The over-all decrease in venereal disease in 1954-55 in the "family living group" was 29 per cent insofar as secondary syphilis is concerned, whereas the State averaged a decrease of but 2 per cent.

"The Venereal Disease Control Committee complimented the Mayor's Youth Committee and the Detroit Board of Education for this fine program and urged its continuation and expansion."

The program of prophylaxis of ophthalmia neonatorum was, likewise, thoroughly discussed as well as the substitution of other drugs for the 1 per cent silver nitrate that is required by State Law to be instilled in the eyes of each newborn infant.

The Venereal Disease Control Committee approved

## ANNUAL REPORTS

the use of broad spectrum antibiotics on an experimental basis in the control of ophthalmia neonatorum and does not recommend a change in the state law on this subject at this time.

Respectfully submitted,  
A. C. CURTIS, M.D., *Chairman*  
RUTH HERRICK, M.D.  
J. A. COWAN, M.D.  
D. K. HIBBS, M.D.  
H. L. KEIM, M.D.  
H. E. LICHTWARDT, M.D.  
L. W. SHAFFER, M.D.  
FRANK STILES, JR., M.D.  
R. S. BREAKEY, M.D.

### ANNUAL REPORT OF COMMITTEE ON STUDY OF PREVENTION OF HIGHWAY ACCIDENT—1955-1956

The Committee had three meetings this past year, plus considerable work by many committee members outside the time of meetings.

**School Bus Driver Examination.**—The Committee has prepared an outline of a physical examination for school bus drivers, who at the present time do not need anything more than a chauffeur's license to qualify. This outline will be distributed to schools by the State Department of Public Instruction as a suggested outline for school boards to require their school bus driver applicants to pass.

**High-school Driver Training Legislation.**—The Committee actively supported the resolution adopted by the MSMS House of Delegates last September urging the Legislature to adopt a driver training law, and had contacts with the Governor and legislators on this subject. Some of the Committee's arguments received editorial comment in the *Detroit Free Press*. Michigan now has probably the most outstanding driver training legislation in the country. At the Traffic Safety Conference held in Chicago in May, this program received more comment than anything else Michigan has done traffic-wise.

**Highway Safety on Extra-Mural Programs.**—Dr. John Sheldon, Chairman of the Extra-mural Postgraduate Education Committee, met with the Traffic Committee for a mutual discussion of this problem. It was moved that two two-man teams be provided for possible use in the extra-mural programs this fall to discuss different aspects of the treatment of highway accidents.

**Local Medical Society Traffic Committees.**—Several local medical societies have formed traffic safety committees after this suggestion was made by the MSMS Committee by way of the Secretary's Letter.

**MSMS Activities at AMA Level.**—The following resolution was initiated by the Committee and introduced by the Michigan delegation at the November meeting of the AMA and was passed unanimously: "That the American Medical Association through its House of Delegates strongly urges the President of the United States to request legislation from Congress authorizing the appointment of a national body to approve and regulate safety standards of automobile construction." This resolution was referred by the AMA to the President's Committee on Traffic Safety.

The Chairman of the Committee introduced a resolution by way of the MSMS House of Delegates and the Michigan delegation to the AMA calling on the AMA to form a committee for the study of highway accidents. This resolution was passed and such a committee has been formed and was responsible for a fine traffic safety scientific exhibit at the June AMA meeting in Chicago, as well as for a half day program at one of the general sessions. Dr. Claire Straith, member of the MSMS Committee, was responsible for one of the exhibits.

A letter was drafted by the Committee and sent in the name of MSMS to Mr. Harlow Curtice, Chairman of the President's Committee on Highway Safety, urging that the AMA be made a member of the Advisory

Council to the President's Committee. This has been done.

The Chairman of the Committee, as a member of Michigan's AMA delegation, appeared before the AMA reference committee considering both of the above mentioned resolutions last November, and also before the reference committee considering a Georgia State Medical Society's resolution on traffic safety at the June meeting of the AMA. At his suggestion the reference committee amended the latter resolution to suggest that some time soon the AMA call a nation-wide conference to consider the medical problems of highway safety, with emphasis being placed on urging individual state medical societies to initiate traffic safety committees. As a result of this the Chairman of the AMA Traffic Study Committee has asked the MSMS Committee to prepare a tentative program for such a meeting.

**Regional Traffic Safety Conference in Chicago.**—This was called by the President's Committee on Traffic Safety. The MSMS Chairman attended by appointment of MSMS President Jones. Three other of the 153 members from Michigan were physicians, representing the Michigan Committee on Trauma. The Conference was called to focus attention on the value of state and local safety councils, with Minnesota's experience as a state and Muskegon's as a small city as examples. The Michigan delegation elected a temporary Action Committee on Traffic Safety to call upon the Governor, of which the Chairman is a member.

**Local Medical Society Participation in Safety Councils.**—The Committee urges that county societies should be alerted to co-operate with local safety councils, and should help to initiate them in areas where they do not exist.

The Chairman would like to thank the very busy members of his Committee for their untiring efforts and wonderful co-operation. No MSMS Chairman could have a better committee!

Respectfully submitted,  
JOHN R. RODGER, M.D., *Chairman*  
G. H. AGATE, M.D.  
W. W. BABCOCK, M.D.  
H. E. DEPREE, M.D.  
J. M. DORSEY, M.D.  
H. F. FALLS, M.D.  
A. Z. HOWARD, M.D.  
H. T. JOHNSON, M.D.  
H. J. MEIER, M.D.  
C. L. STRAITH, M.D.

### OFFICERS NIGHT BANQUET

Wednesday, September 26, 1956

7:00 p.m.

Grand Ballroom, Sheraton-Cadillac Hotel,  
Detroit

Sponsored by MSMS and its Woman's Auxiliary

All MSMS Members and their Ladies Invited

# Technical Exhibits - 1956 Annual Session

**Abbott Laboratories**  
North Chicago, Ill.

**Booth No. 12**

**A. S. Aloe Company**  
St. Louis, Mo.

**Booth No. 75**

Visit Booth No. 75, where the A. S. Aloe Company will have on display a cross section of their most complete line of physical supplies and equipment featuring our Steeline Suite in the new Colonial Blue color.

Your Aloe representatives will certainly appreciate having the opportunity of discussing mutual items of interest with you.

**American Ferment Company**  
New York, N. Y.

**Booth No. 101**

Products to be featured are Tod'l Medicated Lotion for the treatment of infantile skin affections and Falgos, the rapid acting, buffered antacid analgesic that causes no gastric upset. Representatives will also be pleased to demonstrate the advantages of Caroid and Bile Salts tablets, Alcaroid Antacid, and Supligol for biliary therapy.

**Ames Company, Inc.**  
Elkhart, Indiana

**Booth No. 28**

MY-B-DEN, the adenine nucleotide, adenosine-5-monophosphate, found highly effective in the treatment of varicose vein complications, stasis and bursitis. MY-B-DEN preoperatively shortens the waiting period necessitated by poor tissue condition and enhances surgical results.

DECHOLIN. The routine use of this product in geriatric patients has proved most beneficial. Common geriatric problems of constipation, inadequate fat digestion and improper liver function are easily overcome.

**Armour Laboratories**  
Kankakee, Ill.

**Booth No. 9**

The Armour Laboratories booth will feature H.P. Acthar Gel and Tryptar, as well as other specialties of Armour Research. Our representative will be happy to answer questions about Armour Products for anyone who cares to stop at our booth.

**Audio-Digest Foundation**  
Glendale, Calif.

**Booth No. 99**

Audio-Digest Foundation—a subsidiary of the California Medical Association—gives the busy physician an effortless tour through the best of current medical literature each week. This medical tape-recorded "newscast"—compiled and reviewed by a professional Board of Editors—may be heard in the physician's automobile, home or office. The Foundation also offers medical lectures by nationally-recognized authorities.

**Ayerst Laboratories**  
Chicago, Ill.

**Booth No. 58**

The Ayerst exhibit will feature "PREMARIN" Intravenous. Reports from hundreds of users emphasize that "Premarin" Intravenous *rapidly* and *safely* controls spontaneous hemorrhage of practically all types. The Ayerst representatives will be pleased to discuss "Premarin" Intravenous and any other product of Ayerst manufacture with visiting physicians.

**Baby Development Clinic**  
Chicago, Ill.

**Booth No. 13**

BABY DEVELOPMENT CLINIC OFFERS demonstration materials: products and literature helpful in instructing prospective parents in the physical and emotional aspects of parent-child relationships arising out of the daily care of their infants and children; also aids to assist in providing emotional security for their children through school ages.

USEFUL FOR: Prenatal Clinics; Prospective Parents Classes; Postpartum Teaching.

**Baker Laboratories, Inc.**  
Cleveland, Ohio

**Booth No. 60**

You are invited to visit Booth No. 60, where Baker's Modified Milk and Varamel, two successful products for infant feeding, are on display.

Baker representatives will be glad to discuss the practical application of Grade A Milk, adjusted fat composition, zero curd tension, synthetic vitamins and other important factors which help to eliminate many of the problems in modern infant feeding.

**Bard-Parker Co., Inc.**  
Danbury, Conn.

**Booth No. 21**

RACK-PACK . . . gross and half gross units of B-P Rib-Back Surgical Blades ready for sterilization in a matter of seconds. Saves time and labor in the O. R., prevents costly, accidental damage to sharp edges. B-P knife handles, B-P Blade Forceps, B-P Germicide, Chlorophenyl, sterilizing containers, transfer forceps, "C.F." Pipettes and Reese Dermatomy.

**Barry Laboratories, Inc.**  
Detroit, Mich.

**Booth No. 18**

**Baxter Laboratories, Inc.**  
Morton Grove, Ill.

**Booth No. 36**

Baxter Laboratories will display the Travert Electrolyte solutions and the Plexitron solution and blood administration equipment. In addition, there will be the INCERT which is the new unique unit for supplementing parenteral solutions. It provides for the addition of vitamins and other supplementary medication to the parenteral solution container without the use of a syringe and needle.

**Beech-Nut Packing Company**  
New York, N. Y.

**Booth No. 64**

Beech-Nut now has a sample size package of cereal. Come to this exhibit to see these new packets as well as to obtain information on—

- (1) Baby Foods for the geriatric patient.
- (2) Feeding the allergic infant.

**Belle Moss Manufacturing Chemist**  
Detroit, Mich.

**Booth No. 40**

DIAPREX: ointment, for effective treatment and prevention of diaper rash, useful also for adults as well as for children, in heat rash and chafing.

CARBAX: ointment, for relief in all types of eczemas, especially in patients overmedicated with tar and other such preparations.

## TECHNICAL EXHIBITS

### The Borden Company New York, N. Y.

Booth No. 76

There's no better place to talk over the latest information on infant feeding than the Borden Prescription Products booth. On display is the complete line of Borden's infant formula products for every feeding purpose or preference. You can feed almost any baby BREMIL, MULL-SOY (Liquid or Powdered), DRYCO, or BIOLAC.

### Brooks Appliance Company Chicago, Ill.

Booth No. 31

The Brooks Appliance Company will exhibit and describe in detail the technique of applying the combination pressure bandages. The moist medicated Primer bandage plus the Dalzoflex Elastic Adhesive which are used in treating leg ulcers and phlebitis. Elastic stockings, the Nulast Elastic Crepe bandages and Surgical instruments will also be displayed.

### Burdick Corporation Milton, Wisconsin

Booth No. 86

The Burdick equipment to be exhibited will feature their new model EK-2 Electrocardiograph and their Ultrasonic Therapy Equipment, as well as Diathermy apparatus.

The new Portable Ultrasonic Unit Model UT-4 will be on demonstration as well as the larger model UT-1. A Burdick factory representative will be on hand to explain these newest additions to the Burdick line.

### Burroughs Wellcome & Co. Tuckahoe, N. Y.

Booth No. 59

**NEW PRODUCTS:** The extensive research facilities of B. W. & Co., both here and in other countries, are directed to the development of improved therapeutic agents and techniques.

Through such research B. W. & Co. has made notable advances related to leukemia, malaria, diabetes, and diseases of the autonomic nervous system; and to antibiotic, muscle-relaxant, antihistaminic, and anti-nauseant drugs.

An informed staff at our booth will welcome the opportunity to discuss our products and latest developments with you.

### Cambridge Instrument Co. New York, N. Y.

Booth No. 95

The new Cambridge Audio-Visual Heart Sound Recorder; the well-known Cambridge "Simpli-Scribe" Model Direct-Writing Portable Electrocardiograph and the Cambridge Standard String Galvanometer Electrocardiograph, both in the "Simpli-Trol" Portable and the Mobile Model Electrocardiograph-Stethograph with Pulse Recorder, will be displayed at this booth. Also, other important Cambridge instruments, including the Operating Room Cardioscope, Educational Cardioscope, Multi-Channel Direct-Writing Recorder, Electrocardiograph, Plethysmograph, and pH Meters.

The Cambridge Engineers in attendance will be glad to give you complete information on these instruments.

### Carnation Company Los Angeles, Calif.

Booth No. 67

Carnation Company presents Carnation Instant Non-fat Dry Milk Solids, the first and only true instant non-fat dry milk. The "Magic Crystals" process which has resulted in instant solubility and fresh flavor, won the 1955 Food Engineering Award for the year's

major advance in food processing. We cordially invite you to sample this fine product; an excellent, economical source of protein.

### Central Pharmacal Company Seymour, Ind.

Booth No. 97

The exhibit of The Central Pharmacal Company will feature Neocyten, for the relief of pain and muscle spasm; Uritral, an effective antiseptic and analgesic for urinary tract infections; and Biotres, an excellent bactericide and fungicide in ointment form. Literature and full information will be available at the booth.

### Ciba Pharmaceutical Products, Inc. Summit, N. J.

Booth No. 27

CIBA is featuring RITALIN, a new mild stimulant-antidepressant. RITALIN raises depressed patients to normal levels of psychomotor activity without amphetamine-like overstimulation or depressive rebound. Representatives will be present to answer queries on this effective agent.

### Coca-Cola Company Atlanta, Ga.

Booth No. 48

Ice-cold Coca-Cola served through the courtesy and co-operation of the Detroit Coca-Cola Bottling Company and The Coca-Cola Company.

### DePuy Manufacturing Co. Warsaw, Ind.

Booth No. 94

DePuy Manufacturing Company is exhibiting representatives sample of their complete line of splints, fracture equipment, surgical supplies and other related items. The oldest firm in the industry will also have on exhibit many new products. We cordially welcome you to visit with us in our booth, inspect our products, and discuss your problems and ideas with us.

### Desitin Chemical Co. Providence, R. I.

Booth No. 62

**DESITIN OINTMENT:** the pioneer in external cod liver oil therapy.

Indications: diaper rash, slow healing wounds, burns of all degrees, lacerations, hemorrhoids and fissures.

**DESITIN POWDER:** a unique, dainty medicinal powder saturated with cod liver oil.

**DESITIN HEMORRHOIDAL SUPPOSITORIES** with COD LIVER OIL: coats ano-rectal area with soothing, lubricating cod liver oil, gives prompt relief of pain, allays itching.

**DESITIN LOTION:** the original cod liver oil lotion, soothing, protective, mildly astringent and heating, in non-specific dermatitis, pruritus, poison ivy, etc.

### Detroit Creamery Co. Detroit, Mich.

Booth No. 102

### Dictaphone Corporation Detroit, Mich.

Booth No. 34

For busy doctors, Dictaphone Corporation offers the easiest way in the world to stay ahead of paper work. It's the Dictaphone Time-Master dictating machine with plastic Dictabelt record.

For hospitals, it's the Dictaphone Telecord System, adaptable to existing internal dial telephone systems. Telecord keeps medical records complete and accurate at minimum cost.

## TECHNICAL EXHIBITS

### Dietene Company Minneapolis, Minn.

Booth No. 37

Have YOU tasted MERITENE . . . the whole protein supplement that DOES taste good? Visit our booth, enjoy a MERITENE Milk Shake with its multiple nutritive values. While you're there, review the Dietene Diet based on DIETENE Reducing Supplement. It provides the rare combination of low calories (1,000) with high intake of protein and all essential vitamins and minerals in an interesting, effective, SAFE weight reducing diet. Now available in INSTANT form also.

### Doho Chemical Corp. New York, N. Y.

Booth No. 6

DOHO CHEMICAL CORPORATION is pleased to exhibit:  
AURALGAN: Ear medication in Otitis Media and removal of Cerumen.  
OTOSMOSAN: Effective, non-toxic Fungicidal and Bactericidal (Gram negative-Gram positive) in the suppurative and aural dermatomycotic ears.  
RHINALGAN: Nasal decongestant free from systemic or circulatory effect and equally safe to use on infants as well as the aged.  
NEW LARYLGAN: Soothing throat spray and gargle for infectious and non-infectious sore throat involvements.  
Mallon Chemical Corporation, Subsidiary of the Doho Chemical Corporation, is also featuring:  
RECTALGAN: Liquid topical anesthesia, for relief of pain and discomfort in hemorrhoids, pruritus and perineal suturing.  
DERMOPLAST: Aerosol freon propellant spray for fast relief of surface pain, itching, burns and abrasions. Also Obs. & Gyn. use.

### Eaton Laboratories, Inc. Norwich, N. Y.

Booth No. 92

For the treatment of Trichomonas vaginalis vaginitis and the accompanying secondary bacterial infections, Tricofuron (T.M.) Vaginal Suppositories and Powder are now available. The latest clinical data on Furadantin® in the form of tablets and as Furadantin Oral Suspension in treating urinary tract infections and prostatitis will be available.

### Paul B. Elder Co. Bryan, Ohio

Booth No. 69

We cordially invite members of the Michigan State Medical Society and their guests to visit our booth. OXSORALEN® for treatment of vitiligo and RAPAX® Inserts for "timed laxation" will be featured. Our representatives will be glad to discuss BENOQUIN® for treatment of hyperpigmentation and other products of ELDER Research.

### Encyclopedia Americana Grand Rapids, Mich.

Booth No. 39

We will display our 1956 Edition of Encyclopedia Americana—acknowledged by leading educators as the first, finest, and foremost reference work in the English language. Our records prove that they prefer it over all others. Don't forget to register for a beautiful 48-page world atlas in full color—free and without obligation.

### Ethicon, Inc. New Brunswick, N. J.

Booth No. 61

Ethicon CP. Surgical Gut, Tru-Permanized Silk and Other Textile Sutures; Ethicon Atraloc Eyeless Needle Sutures; Bio-Sorb Absorbable Dusting Powder; Gamophen Antiseptic Surgical Soap; Tantalum Gauze & Other Tantalum Surgical Materials; SUTUPAK—Pre-cut Sterile Surgical Silk & Cotton Sutures; Surgical Steel Sutures & Gauze; Surgiset, Pocket Surgiset—

Suture Assortments: LIGAPAK—Spiral Wound Sutures; New Ophthalmic Sutures.

### H. G. Fischer & Co. Detroit, Mich.

Booth No. 41

Latest models of Modern X-Ray Apparatus, F.C.C. approved Ultrasonic Generators, Short Wave Diathermy Units and Low Voltage Generators, all of highest quality materials and construction, will be on display. Representatives in attendance will welcome an opportunity to give demonstrations and quote today's low prices. Your visit will be appreciated.

### C. B. Fleet Company, Inc. Lynchburg, Va.

Booth No. 7

During the past fifty years, PHOSPHO-SODA (FLEET) has been a symbol of elegance in sodium phosphate medication. FLEET ENEMA DISPOSABLE UNIT—an enema solution of Phospho-Soda (Fleet)—is a worthy companion product. The single-use unit simplifies and assures satisfying preparation for proctoscopy and as a routine enema it is a boon to the hospitalized patient.

### Flint, Eaton & Company Decatur, Ill.

Booth No. 46

Flint, Eaton presents Ferrolip, a new chelate complex of iron. Chelated iron, as in Ferrolip, is resistant to all usual chemical forces serving to precipitate iron and to produce iron intolerance; yet the chelated iron in Ferrolip is completely soluble and readily available for uptake along the entire gastrointestinal tract. Visit the Flint, Eaton & Company booth to hear of chelation as it applies to iron therapy.

### E. Fougera & Company, Inc. New York, N. Y.

Booth No. 47

E. FOUGERA & COMPANY, Inc. AND DIVISION, VARICK PHARMACAL COMPANY, Inc., cordially invite physicians to discuss with Professional Service representatives new preparations of importance to their everyday practice. Descriptive literature and samples of all products will be available.

### Freeman Mfg. Company Sturgis, Mich.

Booth No. 72

The Freeman line of Surgical Supports places particular emphasis on orthopaedic braces for use when conservative measures are indicated. Rigid control and almost complete immobilization of the sacral, lumbar and thoracic area is achieved through the use of splint type construction in combination with the block and tackle effect of straps and buckles. Special designs and constructions are available for any purpose.

### Geigy Pharmaceuticals New York, N. Y.

Booth No. 78

MEDOMIN—a new kind of barbiturate—will highlight the GEIGY Exhibit. Indicated for safe, gentle hypnosis and reliable, sustained sedation, MEDOMIN is unique in that a 7-member ring is attached to the barbiturate radical. Also featured will be BUTAZOLIDIN, nonhormonal anti-arthritis; HURAX, antipruritic and scabicide; and STEROSAN, bacteriostat and fungistat.

### General Electric Company Detroit, Mich.

Booth No. 74

X-Ray Department, General Electric Company, manufacturers of complete X-Ray equipment from portable diagnostic to 2,000,000 volt therapy apparatus—electrocardiograph—diathermy—X-Ray accessories and supplies. X-Ray equipment of new design will be shown for the first time at your meeting. We are looking forward to seeing you.

## TECHNICAL EXHIBITS

### Gerber Products Company Fremont, Michigan

Booth No. 35

WHEN MILK IS CONTRAINDICATED as the basic food for infants, Gerber "Meat Base Formula" can provide a nutritionally adequate replacement. It is well accepted and tolerated by infants of all ages. Your Gerber detailman invites you to evaluate "Meat Base Formula" and the complete line of supplementary baby foods.

### Hack Shoe Company Detroit, Mich.

Booth No. 3

RIPPLE SOLES, "The Shoes That Walk For You" will highlight this exhibit.

Doctors and their guests will be invited to try them on so that they may experience the unusual comfort of these cushion-soft shoes.

Other Hack Shoes displayed will include supportive shoes for men and women and regular as well as prescription shoes for children.

### J. F. Hartz Co. Ferndale, Mich.

Booth No. 66

Surgical instruments, diagnostic and office equipment. Pharmaceutical specialties of our own manufacture.

### H. J. Heinz Co. Pittsburgh, Pa.

Booth No. 10

What's New??? These Heinz Varieties—

Strained Foods—Bananas, Creamed Spinach, Macaroni, Tomatoes, Beef & Bacon, Split Peas—Vegetables & Bacon, Egg Yolk.

Junior Foods—Creamed Carrots, Teething Biscuit, Green Beans & Potatoes. Junior Dinner—Vegetables & Lamb; Junior Dinner—Vegetables & Liver.

All Heinz Baby Foods are glass packed except Strained Orange Juice, Teething Biscuits and four Pre-Cooked Cereals.

Literature—Booklet for Mothers—"A Feeding Guide for a Healthy Happy Baby" and for you—Nutritional Data.

### Hoffmann-LaRoche, Inc. Nutley, N. J.

Booth No. 49

### Holland-Rantos Co., Inc. New York, N. Y.

Booth No. 16

Physicians interested in Medical Contraception are invited to discuss with H-R representatives latest information on laboratory and clinical data concerning efficacy of KOROMEX products, particularly the unique new KORO-FLEX Diaphragm.

Also on exhibit will be the trichomonocidal, fungicidal and bactericidal NYLMERATE Jelly and Solution Concentrate, as well as medicated HOLLANDEX Ointment with silicone base and natural vitamin A and D.

### G. A. Ingram Co. Detroit, Mich.

Booth No. 87

THE G. A. INGRAM COMPANY will, as usual, have many new items of interest on display in space 87, and the salesmen in charge of this exhibit will be in a position to give you full information regarding both the new items as well as all other equipment on display. We shall look forward with pleasure to having you stop at our booth to say "hello."

### Instant Sanka Coffee White Plains, New York

Booth No. 5

Just as often as you wish between your meetings, stop by for a cup of INSTANT SANKA. This is 100% pure coffee with 97% of the caffeine removed. And be sure to pick up some samples for a nightcap in your room, and to register for professional samples and copies of the booklet, What Every Coffee Lover Should Know About Caffeine.

### C. B. Kendall Co. Indianapolis, Ind.

Booth No. 77

The C. B. Kendall Company is featuring two recent releases which have already been favored with impressive acceptance. The staff in attendance will welcome an opportunity to detail the qualities of these products.

### Kenfre Mfg. Company Grand Rapids, Mich.

Booth No. 96

AUDIVOX, INC. Successor to *Western Electric* Hearing Aid Division. "The Hearing Aid Your Doctor Knows." Audiometers: Diagnostic, Screening, Pure-Tone, Speech; custom-engineered to individual needs of doctors, hospitals, schools, clinics or industry, **Lectron-O-Scope**, electronic stethoscope for earlier, more complete diagnosis. **Scottie**, pocket-sized telephone amplifier. **Electro-Larynx**, talking device for laryngectomees.

### Kremers-Urban Company Milwaukee 1, Wisconsin

Booth No. 50

The KREMERS-URBAN booth will feature the most potent visceral antispasmodic **LEVSIN SULFATE** . . . **SALIMEPH-C** with its ACTH-like anti-rheumatic activity, but without side effects . . . **NITROL TABLETS-OINTMENT** for the prevention of anginal attacks and **AMITRATE** for coronary insufficiency.

### A. Kuhlman & Co. Detroit, Mich.

Booth No. 38

The A. Kuhlman & Co., celebrating its ninetieth year in the physicians and hospital supply business in Detroit, invites you to see its display of the latest diagnostic and surgical instruments as well as examining room furniture and physical therapy equipment.

### Lea & Febiger Philadelphia, Pa.

Booth No. 89

Be sure to see these 1956 and other recent books: Wintrobe—Clinical Hematology; Wohl and Goodhart—Modern Nutrition in Health and Disease; Soffer—Diseases of the Endocrine Glands; Zimmerman, Netsky and Davidoff—Atlas of Tumors of the Nervous System; Katz and Pick—Clinical Electrocardiography; Master, Moser and Jaffe—Cardiac Emergencies and Heart Failure; Lewin—The Back and Its Disk Syndromes; Ritvo—Chest X-Ray Diagnosis; Stimson—Fractures; Cushman—Strabismus; Epstein—Skin Surgery.

### Lederle Laboratories Pearl River, N. Y.

Booth No. 30

You are cordially invited to visit the Lederle booth where our medical representatives will be in attendance to provide the latest information and literature available on our line.

Featured will be Achromycin, Diamox, Vitamins, Pathilon, Varidase and many other of our dependable products.

### Liebel-Flarsheim Company Cincinnati, Ohio

Booth No. 15

The Liebel-Flarsheim Company cordially invites you to visit the booth in which their latest electromedical-electrosurgical equipment will be exhibited. We ask particularly that you stop and see the L-F Basal-Meter, the first automatic, self-calculating metabolism unit ever offered. Capable representatives will be on hand at all times.

## TECHNICAL EXHIBITS

### Eli Lilly & Company Indianapolis, Ind.

Booth No. 91

You are cordially invited to visit the Lilly exhibit located in space No. 91. The display will contain information on recent therapeutic developments. Lilly sales people will be in attendance. They welcome your questions about Lilly products.

### J. B. Lippincott Co. Philadelphia, Pa.

Booth No. 17

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

### Maico Detroit Company Detroit, Mich.

Booth No. 88

The new Maico Hearing Aid weighing less than one-half ounce is so small that the entire unit consisting of transmitter, microphone, receiver, battery and ear mold is worn in the ear. A complete line of instruments to take care of cases from the borderline to the profoundly deaf.

90% of all precision hearing test instruments used in America by ear physicians are Maico.

### Maltbie Laboratories Division Belleville, N. J.

Booth No. 44

You are cordially invited to visit the Maltbie Exhibit to meet our representatives and discuss our ethical pharmaceutical products. Featured items will be DESENEX and SALUNDEK, the well-known fungicides; CHOLAN HMB, for comprehensive biliary therapy; MALCOTRAN, the potent anticholinergic with wide margin of safety; and CALPURATE, for improved cardiac function and increased diuresis.

### S. E. Massengill Co. Bristol, Tenn.

Booth No. 55

SALCORT, a judicious combination of Salicylates and Cortisone for the treatment of arthritic and rheumatoid affections.

and

HOMAGENETS, the homogenized vitamins. A liquid suspension in a solid form, Homagenets may be chewed, swallowed or allowed to dissolve on the tongue. Homogenized vitamins are better absorbed, better utilized and large vitamin excesses are unnecessary.

### Mead Johnson & Co. Evansville, Indiana

Booth No. 90

The new Deca vitamin family for the vital first decade of life will be exhibited by Mead Johnson & Company in Booth No. 90. Included in the new Deca family of vitamin specialties are: Deco-Vi-Sol, for dropper dosage, a fruit flavored solution for infants and toddlers; Deca-Mulcin, for teaspoon dosage, a pleasantly-flavored liquid for preschool children of 2 to 6 years; and Deca-Vi-Caps, small, easily-swallowed capsules, for school-agers of 6 to 10 years. All three Deca vitamin specialties supply 10 nutritionally significant vitamins including A, C, and D, plus 7 important B vitamins.

### Medco Products Co. Tulsa, Okla.

Booth No. 100

Featuring the MEDCO-SONLATOR. A new concept in therapy, combining muscle stimulation and ultrasound simultaneously through a SINGLE three way sound applicator.

The MEDCO-SONLATOR is a distinct advance in the effectiveness of physical therapy in your office or hospital. A few minutes spent in our booth should prove of value to your practice.

### Medical Arts Supply Co. Grand Rapids, Mich.

Booth No. 79

Your friendly, competent Medical Arts representatives invite you to see the latest in modern furniture and equipment as well as a number of dramatic new developments in medical and surgical techniques and materials. Stop by and let us say, "Hello."

### Medical Protective Company Fort Wayne, Ind.

Booth No. 20

MALPRACTICE PROPHYLAXIS. Policyholders of The Medical Protective Company are in less jeopardy from malpractice claims and suits today than they have been for the past thirty years. In fact, 1955 brought less than half as many claims and suits as were filed against fewer policyholders twenty years ago. Specialized Service makes our doctor safer.

### Merck Sharp & Dohme, Inc. Philadelphia, Pa.

Booth No. 29

The Sharp & Dohme exhibit presents "Co-Deltra" and "Co-Hydeltra," specifically designed to provide all the benefits of prednisone and prednisolone plus positive antacid action to minimize gastric distress. Related adrenal cortical steroid preparations in endocrine disorders, collagen diseases, respiratory allergies, eye diseases and skin conditions are also highlighted.

"Cathomycin," a new and potent antibacterial agent of great clinical significance, will be of interest. "Cathomycin" has been proved highly efficient in its action against Staphylococci and some strains of Proteus vulgaris resistant to all other known antibiotics. Expertly trained personnel will be pleased to discuss new dosage forms, new indications, and the latest summaries of advanced clinical reports in these fields.

### Wm. S. Merrell Co. Cincinnati, Ohio

Booth No. 26

Merrell representatives will be on hand to discuss TACE, a new distinctive estrogen and Meratran, a new unique antidepressant. Please stop at Booth No. 26, where our representatives will be happy to talk with you.

### Meyer and Company St. Clair Shores, Mich.

Booth No. 43

ATHEMOL: A new compound for the treatment of arteriosclerosis and its consequences: arterial hypertension, cerebral sclerosis, coronary sclerosis, ringing in the ears, faintness and difficulties of hearing, headaches and general afflictions of aging people, climacteric difficulties, et cetera.

DEXALME L.A.: The timed disintegrating capsules which release 10 or 15 mg. of dextro amphetamine over a period of nine hours.

TESTALDIOL BUCCAL TABLETS: METHYL TESTOSTERONE and ESTRADIOL in buccal absorption tablets.

### Michigan Medical Service Detroit, Mich.

Booth No. 4

The Blue Shield exhibit exemplifies the prepayment plan sponsored by the doctors of Michigan and what that plan means to the people of the state. The family scene is typical of a family which has been relieved of the worry of catastrophic medical bills. The photograph of the doctor and the child which makes up the Blue Shield portion of the exhibit is symbolic of the co-operation of the doctors of Michigan. Through that co-operation, Blue Shield in Michigan has led the nation in meeting the needs of the public.

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AUGUST.

## TECHNICAL EXHIBITS

**No. 79** **Miller Surgical Company** **Booth No. 68**  
Chicago, Ill.

See the Miller explosion proof Gorsch Operating Rectoscopes with attached tubes for insufflation of carbon dioxide to prevent intrabowel explosions during electro-surgery. The popular Miller Electro-Surgical Units with Snares, Suction-Coagulation attachments, Forceps and other special accessories will also be featured as well as our illuminated Oscopes, Ophthalmoscope, Eyespud with Magnet, Transilluminating Lamps, Lempert type Headlite, Vaginal Speculum with Smoke Ejector and Gorsch Stainless Steel Proctoscopes with Magnification.

**No. 20** **Nepera Chemical Co., Inc.** **Booth No. 80**  
Yonkers, N. Y.

The Nepera exhibit features a new drug, Choleldyl, which has been highly effective in the treatment of bronchial asthma, bronchospasm and congestive heart failure. Choleldyl assures high oral theophylline blood levels, with minimal side reactions; it rarely produces fastness.

Also featured—Urosulfon, a new product, which is a combination of a well-known soluble sulfonamide for antibacterial effect and a widely-used azo dye for rapid symptomatic relief of pain, burning, frequency, etc., in the treatment of urinary infections, especially cystitis of pregnancy.

Mandelamine, a urinary antiseptic.

**No. 29** **Wm. R. Niedelson Co.** **Booth No. 1**  
Detroit, Mich.

The Jones AIR-BASAL—the Profexray ROCKET series and other diagnostic equipment in the latest designs will be demonstrated. Ultrasound equipment and techniques will be fully described to those interested in the newest modality in Physio-Therapy today.

**No. 26** **Noble-Blackmer, Inc.** **Booth No. 32**  
Jackson, Mich.

It is a pleasure to look forward to September and the Michigan State Medical Society Convention when we will once again be able to say "Hello" to our many doctor friends. Our exhibit this year will be in Booth 32 in the first room. Please stop in and see us.

**No. 43** **Ortho Pharmaceutical Corporation** **Booth No. 8**  
Raritan, N. J.

ORTHO cordially invites you to Booth No. 8 where the well-known line of obstetrical and gynecological pharmaceuticals will be on display. Particular emphasis will be placed on Ortho preparations for conception control. Ortho representatives will be on hand to offer pertinent information on their products.

**No. 4** **Parke, Davis & Co.** **Booth No. 14**  
Detroit, Mich.

Medical service members of our staff will be in attendance at our exhibit for consultation and discussion of various products. Important specialties, such as Penicillin S-R, Benadryl, Ambodryl, Dilantin Suspension, Vitamins, Oxycel, Milontin, Amphetase, Chloromycetin, Thrombin Topical, etc., will be featured. You are cordially invited to visit our exhibit.

**No. 4** **Pelton & Crane Company** **Booth No. 82**  
Charlotte, N. C.

Fast autoclaves in three sizes will be demonstrated and explained. Pelton autoclaves are the only self-contained (not connected to plumbing) units that generate, then store steam under pressure to be drawn on whenever you wish to sterilize. No waiting time between loads. One filling with water is usually sufficient for 8 hours of continuous operation.

**Pet Milk Company**  
St. Louis, Mo.

We shall be pleased to have you stop and discuss the variety of time-saving material available to busy physicians. Our representatives will be on hand to discuss the merits of "Pet" Evaporated Milk for infant feeding and INSTANT "Pet" Nonfat Dry Milk for special diets. A miniature "Pet" Evaporated Milk can will be given to all visitors.

**Pfizer Laboratories**  
Brooklyn, N. Y.

The Pfizer exhibit again will be in the spotlight with its new and original concept of anti-stress, anti-infective therapy—TETRACYN S. F. and TERRAMYCIN S. F. (Stress Fortified). Also the complete line of Pfizer antibiotics and STERAJECT as well as the new specialties, BONAMINE, TYZINE, TOCLASE and the complete line of steroid hormones including CORTIL and the latest corticosteroid STERANE (brand of prednisolone).

**Picker X-ray Corporation**  
White Plains, N. Y.

"Dial-the-part" automation distinguishes the new Picker Anatomic Century II x-ray unit. Simple to use, it eliminates the need for technique charts or manual setting of separate technique factors. The operator merely "dials" the body part, makes a simple thickness-of-part setting, and pushes a button for the exposures. Coupled with this control is a new full size motor-driven table with a single x-ray tube quickly changed over from fluoroscopy to radiography.

**Procter and Gamble Company**  
Cincinnati, Ohio

Ivory Soap (Procter & Gamble) offers a series of time-saving leaflet pads for doctors, each pad containing fifty identical tear-out sheets. These sheets which may be given to patients, contain routine instructions covering six different topics. There are also samples of other free, helpful material prepared especially for physicians.

Mrs. Christyne Schwab in charge.

**Professional Management**  
Battle Creek, Mich.



**PROFESSIONAL MANAGEMENT**  
**MORE INCOME—MORE FREEDOM FROM DETAIL—MORE LEISURE TIME—BETTER PATIENT MANAGEMENT—BETTER PUBLIC RELATIONS**

Doctors interested in attaining any of these objectives are invited to stop at Booth No. 85 and talk with the PM executives. Since 1932 their management counsel has helped thousands of physicians.

**Purdue Frederick Company**  
New York, N. Y.

The Purdue Frederick Company will feature SENOKOT—new non-bulk, non-irritating constipation corrective acting selectively on the parasympathetic (Auerbach's) plexus in the large bowel, physiologically stimulating the neuromuscular defecatory reflex.

PRE-MENS—the multidimensional premenstrual tension therapy.

COLPOTAB—a tested effective Tyrothricin trichomonocide; and

CHLOROGIENE—a hygienic douche formulation.

**Booth No. 22**

**Booth No. 84**

**Booth No. 53**

**Booth No. 25**

**Booth No. 85**

**Booth No. 98**

## TECHNICAL EXHIBITS

**Randolph Surgical Supply Co.**  
Detroit, Mich.

Booth Nos. 51, 52

**R. J. Reynolds Tobacco Co.**  
Winston-Salem, N. C.

Booth No. 81

Welcome to the R. J. Reynolds Tobacco Company Exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMEL, CAVALIER King Size, or WINSTON, the distinctive new king size filter cigarette.

**A. H. Robins Co., Inc.**  
Richmond, Va.

Booth No. 63

Physicians attending the meeting of the Michigan State Medical Society are extended a cordial invitation to visit the exhibit of the products of the A. H. Robins Company. Experienced medical representatives will be in attendance to welcome you and answer inquiries relative to any of Robins prescription specialties.

**J. B. Roerig & Co.**  
Chicago, Ill.

Booth No. 45

J. B. ROERIG AND COMPANY, booth 45, will highlight ATARAX, the new "Peace of Mind" drug. It's an all new chemical and is considered an achievement in the quest for a better ataraxic. ATARAX is particularly indicated for the "more normal" person and brings relief from the common everyday anxieties and annoyances. It is quick acting yet requires low mg. dosage; does not disturb the mental acuity of the patient and has virtually no known side effects. Literature and samples available at the booth, which you and your friends are cordially invited to visit.

**Ross Laboratories**  
Columbus, Ohio

Booth No. 11

ROSS LABORATORIES: Current concepts in infant feeding stress the critical aspects of preventive care. Visit our booth at your convenience; your Similac representative will be happy to discuss the physiologic role of Similac Powder and Similac Liquid in providing good growth, sound development, and optimum clinical benefits. Reprints of current pediatric investigations and the latest Ross Research Conference Reports are available.

**Sandoz Pharmaceuticals**  
Hanover, N. J.

Booth No. 56

**W. B. Saunders Company**  
Philadelphia, Pa.

Booth No. 2

Harold Rozema will again be on hand with the complete Saunders line. Among the newest of special interest are: Friedberg: Diseases of the Heart, Pillsbury: Dermatology, Fluhmann: Menstrual Disorders and Modell: Relief of Symptoms.

**Schering Corporation**  
Bloomfield, N. J.

Booth No. 19

A cordial invitation is extended to the members of the Michigan State Medical Society to visit the Schering exhibit, Booth No. 19. The entire exhibit will be devoted to METICORTEN and METICORTELONE, the new corticosteroids for the treatment of rheumatoid arthritis, intractable asthma and other so-called collagen diseases. Extensive clinical and laboratory data demonstrating certain advantages of these new steroids over cortisone and hydrocortisone are shown.

**Julius Schmid, Inc.**  
New York, N. Y.

Booth No. 70

An interesting and informative exhibit featuring RAMSES Flexible Cushioned Diaphragm; RAMSES Vaginal Jelly; VAGISEC Jelly and Liquid, two new products embodying "Carlendacide," the recent development of Carl Henry Davis, M.D., and C. G. Grand for vaginal trichomoniasis therapy; and XXXX (FOUREX) Skin Condoms, RAMSES and SHEIK Rubber Condoms for the control of trichomonal infection.

**G. D. Searle & Co.**  
Chicago, Ill.

Booth No. 93

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research. Featured will be Nilevar, the new anabolic agent; Mictine, the new safe, non-mercurial oral diuretic; Vallestiril, the new synthetic estrogen with extremely low incidence of side reactions; Banthine and Pro-Banthine, the standards in anti-cholinergic therapy; and Dramamine, for the prevention and treatment of motion sickness and other nauseas.

**Smith, Kline & French Labs.**  
Philadelphia, Pa.

Booth No. 23

Have you ever wondered why "Thorazine" is indicated in so many seemingly unrelated conditions? If you will stop at our booth, SKF Representatives will be glad to answer this question for you. And be sure to ask for new information on "Cytomel"—the modern method of treating the syndrome of metabolic insufficiency. We'll look forward to seeing you.

**Testagar & Co., Inc.**  
Detroit, Mich.

Booth No. 33

The representatives of Testagar & Co., Inc., will display five new timed disintegrating capsules: Timed Amodex, Timed Tridex, Timed Bar-Tropin, Timed Pyma, and Timed Pymadex Capsules. Samples and literature will be available. They will also have samples and literature on a very new skeletal muscle relaxant, Myomphetane, and a new oral procaine product, Ascorbacaine Capsules used in the treatment of Pruritus. The representatives of Testagar & Co. will be very happy to say Hello. Stop by.

**S. J. Tutag & Co.**  
Detroit, Mich.

Booth No. 71

Tutag is proud to present Buffonamide, the triple sulfa that is buffered. The use of sodium citrate as buffering agent with the acetdiamer-sulfonamides makes Buffonamide ideal; this formula is less toxic, well-tolerated, readily absorbed, with increased crystalluria protection. The pleasant cherry flavoring of this suspension makes Buffonamide the drug of choice for all ages.

Another featured item will be Tutag's Parazine (brand of Piperazine Citrate) which is an excellent pleasant tasting liquid used in the control of pinworms and roundworms. Parazine eliminates the adjunctive use of fasting, enemata and purges. It is well tolerated and effective. Also available in tablet form.

**The Upjohn Company**  
Kalamazoo, Mich.

Booth No. 54

The Upjohn Company exhibit in Booth No. 54 will feature products of current interest to the medical profession. You are especially invited to attend the continuous showing of the Grand Rounds films, Acute

## TECHNICAL EXHIBITS

abdominal Problems and The Cardiac Patient in Stress, in the "Upjohn Cinema Room" beginning at 9:00 A.M. through 5:00 P.M. daily.

U. S. Vitamin Corp.  
New York, N. Y.

Booth No. 65

Exhibit features ARLIDIN, an entirely new, relatively safe and effective vasodilator drug with three unique pharmacologic actions: (1) dilates predominantly small blood vessels of skeletal muscle, (2) increases circulating blood volume, (3) increases cardiac output. Thus, ARLIDIN (Nylidrin HCl. MNR) is indicated in treating intermittent claudication and a wide range of functional and obliterative disorders of peripheral vascular insufficiency. Professional samples and literature distributed also on our complete line of nutritional and pharmaceutical specialties.

Warner-Chilcott Laboratories  
New York, N. Y.

Booth No. 83

A visit to the Warner-Chilcott booth will pay dividends, especially in the interests of your cardiovascular patients. The company is featuring two "clinically tested and proven agents": one to help you prevent attacks of angina pectoris; the other, the most potent drug currently available for reduction of blood pressure in hypertensive patients.

Westwood Pharmaceuticals  
Buffalo, N. Y.

Booth No. 57

White Laboratories  
Kenilworth, N. J.

Booth No. 42

Stimulate appetite—improve muscle tone—speed convalescence through a more efficient utilization of protein. "Correct proportion of amino acids to each other in the diet is more important than total protein intake." White's L-lysine preparations—LACTOFORT, CEROFORT TABLETS and CEROFORT ELIXIR—raise milk, cereal and vegetable proteins to high values.

Winthrop Laboratories, Inc.  
New York, N. Y.

Booth No. 73

New A.P.C.-Demerol tablets for potentiated pain relief. Each tablet contains aspirin 3 grains, phenacetin 2½ grains, caffeine ½ grain with demerol hydrochloride 30 mg. A.P.C.-Demerol tablets combine marked potentiation of analgesia with mild sedation and spasmolytic action. They do not cause constipation nor interference with micturition.

Zimmer Mfg. Co.  
Toledo, Ohio

Booth No. 24

Mr. C. A. Fisher, your Zimmer Distributor, extends most cordial invitation to the members of the Michigan State Medical Society to visit his exhibit at BOOTH 24.

A complete line of Orthopedic Instruments and Fracture Equipment will be on display. Items of special interest, BADGLEY NAIL AND PLATE, TOWNLEY CUP STEM PROSTHESIS, SCHNEIDER SELF-BROACHING INTRAMEDULLARY PINS, TITANIUM IMPLANTS, EXPLOSION PROOF LUCK BONE SAW AND BROWN-ELECTRO DERMATONE (underwriters approved), MYO-CERVICAL COLLAR.

ZIMMER, your guarantee of quality and prompt service.

## HOTEL RESERVATIONS

### MICHIGAN STATE MEDICAL SOCIETY

91st Annual Session

Detroit, September 26-27-28, 1956

The reservation blank below is for your convenience in making your hotel reservations in Detroit. Please send your application to the Committee on Hotels for MSMS Convention, Att: B. Van DeKeere, Sheraton-Cadillac Hotel, Detroit, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Committee on Hotels by sharing a room with another registrant, when convenient.

Committee on Hotels,  
Michigan State Medical Society  
c/o Sheraton-Cadillac Hotel  
Detroit, Michigan

Att: B. Van DeKeere

Please make hotel reservation(s) as indicated below:

\_\_\_\_\_ Single Room(s) \_\_\_\_\_ persons

\_\_\_\_\_ Double Room(s) for \_\_\_\_\_ persons

\_\_\_\_\_ Twin-Bedded Room(s) for \_\_\_\_\_ persons

Arriving September \_\_\_\_\_ hour \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

Leaving \_\_\_\_\_ hour \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

Hotel of First Choice: \_\_\_\_\_

Second Choice: \_\_\_\_\_

Name and addresses of all applicants including person making reservation:

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AUGUST, 1956

1003

# Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

## POLIO IMMUNIZATION PROGRAM BROADENED

On the recommendation of the State Advisory Committee on Polio Vaccine Distribution, Rule 8 of the Rules and Administrative Policies Governing the Distribution and Use of Poliomyelitis Vaccine was amended as of June 26 to permit third doses to persons within the priority group. The priority group remains children from one through fourteen and pregnant women, with the age of the boy or girl at the time of first injection the deciding factor as to whether he or she is in the priority group.

The only limitation on third doses to the priority group is that the third dose will not be given until at least six months after the second dose. The third dose boosts the immunity level most effectively if it is given at least six months after the second dose.

A second change was made in Rule 8. Hospitals providing definitive treatment for acute poliomyelitis cases may purchase poliomyelitis vaccine for administration to persons who are providing direct care to patients with acute poliomyelitis.

## POLIO VACCINE NOW RELEASED THROUGH COMMERCIAL CHANNELS

A portion of each allocation of poliomyelitis vaccine to Michigan is now being released through commercial channels. This does not materially affect the poliomyelitis vaccination program.

1. The amount of vaccine purchased by the Michigan Department of Health plus the amount going to commercial channels in Michigan will still amount to 4.308 per cent of all vaccine released by the Public Health Service. Previously the Michigan Department of Health was purchasing the entire 4.308 per cent.

2. Each health jurisdiction will continue to be offered their proportionate share of all vaccine purchased by the Michigan Department of Health.

3. All vaccine coming into Michigan, whether for local purchase or for distribution by local health departments, will still have to be used within the current priority group.

4. Physicians will continue to complete and send to the local health department a vaccine usage card, whether the vaccine used is material purchased by him or material supplied to him by the local health department. These vaccine usage cards will be supplied by the local health department.

5. Drug stores and surgical supply houses will report weekly to the local health departments the amount of vaccine received by them during the week and the amount of vaccine sold during the week, giving the date of sale, the name and address of the purchaser, the name of the manufacturer, the lot number, and the

number of ccs. sold to each purchaser. This will be reported to local health departments on form PHS 2434 and after the local health department has made a note of this information, form PHS 2434 should be sent to the Division of Disease Control, Records and Statistics.

6. The manufacturer will, on a daily basis, provide the Michigan Department of Health with copies of invoices covering any shipments made directly to physicians within the state. The Michigan Department of Health in turn will transmit this information to the local health departments into whose jurisdiction the vaccine was shipped.

## SPECIAL TB AND VD SURVEYS PLANNED

Special TB and VD surveys to be conducted during July and August include a program in the Traverse City area from July 23 through August 10. This will be sponsored by the Michigan Cherry Growers Association. It is estimated that approximately 15,000 to 20,000 persons will be in the cherry orchards during the time that the survey is in operation.

For the third year, x-ray service will be provided to the Merchant Marine at the Soo Locks through the Lake Carriers' Association and the Public Health Service. It will begin on August 13 and extend through August 30. Screening films are taken while the ships are passing through the Locks and the men come in groups of five to eight and return immediately to their ships.

## VAN BUREN SCREENING RESULTS REPORTED

In the migrant labor TB and VD screening program carried on in Van Buren County from June 12 to 21, a total of 1,345 X-ray films were taken. Suspect abnormalities totalled twenty-six, of which thirteen were suspect reinfection TB, five were suspect cardiovascular and one was a suspect neoplasm. Abnormalities were reported daily by telephone to the Van Buren County Health Department and patients were transported to the Southwestern Michigan TB Sanatorium for re-evaluation and 14 x 17 films.

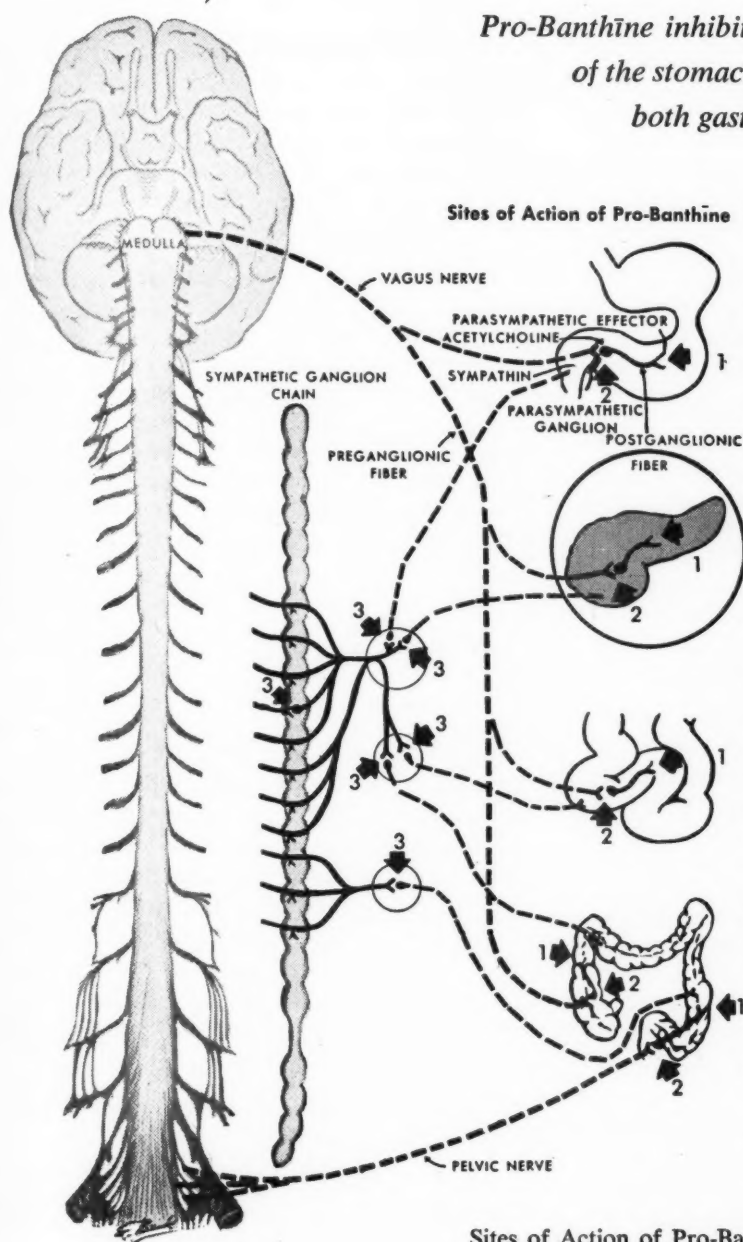
A total of 1,147 persons had blood tests. Of these fifteen were reported positive or doubtful.

About 57 per cent of population of Greater New York area is enrolled in New York City Blue Cross. Plan added 411,799 subscribers during 1955, bringing total enrollment to 6,168,968. During year subscribers received benefits valued at \$107,873,577, bringing total benefits given since plan was founded in 1935 up to \$684,353,562. Operating expenses were eight per cent.

PROVED ANTICHOLINERGIC EFFICIENCY

# Pro-Banthine® Provides Rapid Relief in Acute Pancreatitis

*Pro-Banthine inhibits excessive vagal stimulation of the stomach and pancreas and reduces<sup>1,2</sup> both gastric and pancreatic secretions.*



With use of the Levin tube and a drug "such as Pro-Banthine . . . most cases of acute pancreatitis<sup>3</sup> will subside in a few hours, or at the most, in a few days."

Schwartz and Hinton achieved<sup>4</sup> dramatic relief of pain in four of six patients with acute hemorrhagic or edematous pancreatitis within twenty to thirty minutes after giving Pro-Banthine intramuscularly. A dose of 15 to 30 mg. may be repeated<sup>1</sup> parenterally at intervals of six hours.

Pro-Banthine bromide (brand of propantheline bromide) also has proved highly effective in the therapy of peptic ulcer, hypertrophic gastritis, diverticulitis, biliary dyskinesia, ileostomies and genitourinary spasm. G. D. Searle & Co., Research in the Service of Medicine.

1. Jones, C. A.: Arch. Int. Med. 96:332 (Sept.) 1955.
2. Zollinger, R. M.: Postgrad. Med. 15: 323 (April) 1954.
3. Woodward, E. R.: M. Clin. North America 38:115 (Jan.) 1954.
4. Schwartz, I. R., and Hinton, J. W.: Personal communication, February, 1955.

**Sites of Action of Pro-Banthine.** The principal site of action of Pro-Banthine is on the parasympathetic system where it exerts a dual action while exerting a single and lesser action on the sympathetic system: (1) parasympathetic effector; (2) parasympathetic ganglion; (3) sympathetic ganglion (see arrows).

SEARLE

## In Memoriam

**Clark D. Brooks, M.D.**, seventy-eight, widely-known Detroit surgeon and member of Detroit Board of Education 1939-1953. Born in Oakland County, attended public schools in Birmingham, and earned his medical degree in 1905 from Detroit College of Medicine and Surgery, now Wayne State University College of Medicine. Interned at Harper Hospital, where he was associated throughout his career. Major, Army Medical Corps in World War I. Died suddenly in his office May 28, 1956.

**Thies C. DeYoung, M.D.**, sixty-two, of Sparta. Born in Grand Rapids, graduated from Michigan State University and Loyola University Medical School, Chicago. Interned at St. Mary's Hospital, Grand Rapids, and practiced in Sparta since 1929. Village health officer since 1930. A son, Maynard DeYoung, M.D., associated in practice from January, 1956. Died suddenly April 10, 1956.

**Lester J. Harris, M.D.**, eighty-four, one of Jackson's oldest practicing physicians. A native of Tompkins Center, past president of Jackson County Medical Society and holder of MSMS 50-Year Award. Chairman of the Board and former President of the Security Savings & Loan Association; Charter Member of the Jackson Exchange Club and former State President of Exchange. Died April 26, 1956.

**F. Pitkin Husted, M.D.**, fifty-one, of Bay City, President-elect of Bay County Medical Society, established surgical practice in Bay City in 1933, following four years on the staff of University Hospital, Ann Arbor. Born in Massachusetts, graduated from Highland Park High School, Syracuse University, and University of Michigan Medical School. Served five years in Army Medical Corps during World War II, overseas in Africa and Europe, attaining rank of Colonel. Following war service, spent a year in postgraduate residency and cancer research at University Hospital. Died unexpectedly May 17, 1956, while visiting in Miami Beach, Fla.

**Dale M. King, M.D.**, eighty-one, well-known Detroit psychiatrist. Born in St. Thomas, Ont. Attended Western Medical School, London, Ont.; University of Michigan Medical School, and Cleveland University School of Medicine, where he was graduated in 1896. Further study at Ohio State University Medical School. Established practice in mental and nervous diseases in Detroit in 1906 after 10 years of general practice in Mount Pleasant. Associated with Receiving Hospital until retirement in 1940; earlier held clinic in mental diseases at Grace Hospital 1907-1917. Died April 29, 1956.

**Torrance Reed, M.D.**, sixty-six, physician and surgeon in Grand Rapids for thirty-six years. Native of Chicago, graduated from high school in Grand Rapids and received M.D. degree in 1912 from University of Illinois. Overseas veteran of Army Medical Corps in World War I. Died April 26, 1956.

**Dwight F. Scott, M.D.**, forty-eight, Sault Ste. Marie obstetrician. Born in Chicago, received both his undergraduate and medical schooling at Northwestern University, earning his M.D. degree in 1934. Interned in Wesley Memorial Hospital, Chicago, and entered private practice at the Sault in 1936. Died May 2, 1956.

**Joseph H. Sherk, M.D.**, seventy-three, prominent physician in Midland, where he had practiced since 1915. Established first practice at St. Ignace in 1906, following graduation from Detroit College of Medicine (Wayne State University College of Medicine). Born in Ontario. Charter member of Midland Rotary Club and active in many civic affairs; member of Board of Education 1922-1934, Planning Commission 1926-1948. Midland County Medical Society nominee for "Michigan's Foremost Family Physician of 1956." Died suddenly June 8, 1956.

**David L. Treat, M.D.**, eighty-two, of Flint, former Postmaster of that city and a resident there since 1916. Born in Adrian; received A.B. and M.D. degrees from Ohio State University. After graduation, practiced 18 years in Adrian, where he served three terms as Mayor and was President of the National Bank of Commerce. Dr. Treat moved to Flint in 1916 as chief surgeon of the Buick Company, a post which he held until entering private practice in 1932. Flint postmaster from 1934 until his retirement in 1949. In poor health for several years, he died April 23, 1956.

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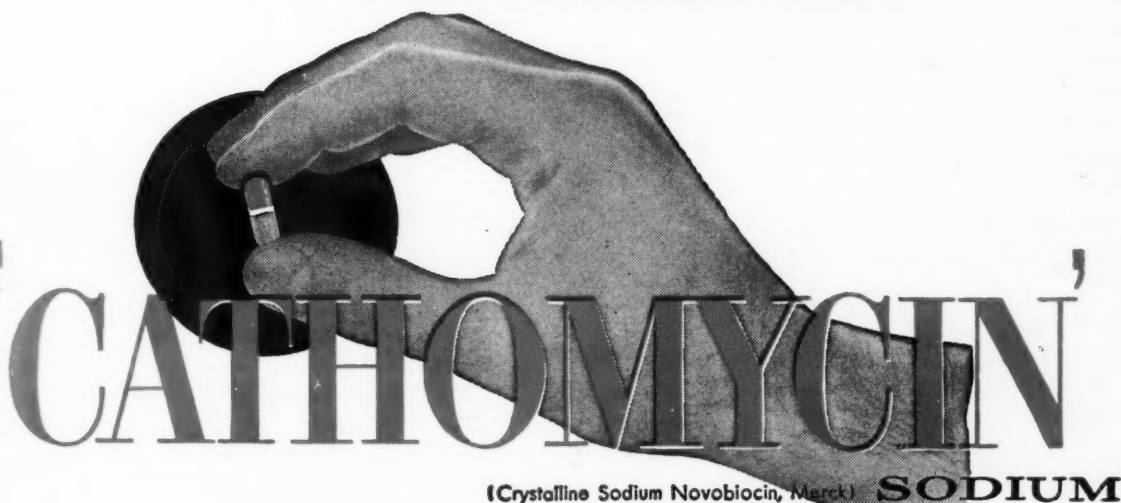
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## NEWS MEDICAL

### MICHIGAN AUTHORS

P. J. Melnick, M.D., and Harry M. Walsh, M.D., Eloise, are the authors of an article entitled "Carcinoma *In Situ* of the Uterine Cervix," published in *Surgery, Gynecology and Obstetrics*, June, 1956.

Bruce E. Cohan, B.S., Ann Arbor, is the author of of an article entitled "Aqueous Humor Outflow; An Experiment Study Using Radiopaque Materials," published in *AMA Archives of Ophthalmology*, June, 1956.

Gordon C. Brown, Sc.D., and Donald C. Smith, M.D., Ann Arbor, are the authors of an article entitled "Sero-logic Response of Infants and Preschool Children to Poliomyelitis Vaccine," published in *The Journal AMA*, June 2, 1956.

Harold F. Schuknecht, M.D., Detroit, and Roderick C. Davison, M.D., Winnipeg, Man., Canada, are the authors of an article entitled "Deafness and Vertigo from Head Injury," published in *AMA Archives of Otolaryngology*, May, 1956.

Gerald S. Wilson, M.D., Joel E. Powers, M.D., and Charles G. Johnston, M.D., Detroit, are the authors of an article entitled "Cancer of the Esophagus," published in *AMA Archives of Surgery*, May, 1956.

Prescott Jordan, Jr., M.D., Thomas B. Patton, M.D., and Clifford D. Benson, M.D., Detroit, are the authors of an article entitled "Portal Hypertension in Infants and Children," published in *AMA Archives of Surgery*, May, 1956.

Fred Jenner Hodges, M.D., Ann Arbor, is the author of an article entitled "The Position of Radiology in Cardiovascular Diagnosis," published in *Minnesota Medicine*, May, 1956.

Kingsley M. Stevens, West Point, Pennsylvania, and Philip A. Riley, M.D., Jackson, are the authors of an article entitled "*In Vivo* Studies on Precipitin Production by the Rabbit Spleen," published in the *Journal of Immunology*, March, 1956.

Philip A. Riley, Jr., Jackson, Timothy G. Barila, Captain, MC, USA, and Carl W. Hughes, Lt. Colonel, MC, USA, are the authors of an article entitled "Ventricular Fibrillation in Hypothermic Dogs as Influenced by Thiopental, Pentobarbital and Succinylcholine," published in *Anesthesiology*, March, 1956.

James E. Coyle, M.D., Detroit, is the author of an article entitled "Radiation Therapy Viewed by the Otolaryngologist," published in *Annals of Otolaryngology and Laryngology*, December, 1955.

James E. Coyle, M.D., and Samuel L. Balofsky, M.D., Detroit, are the authors of an article entitled "Current Trends in Radiotherapy of Head and Neck Cancer," published in *Transactions, American Academy of Ophthalmology and Otolaryngology*, March-April, 1955.

Harry M. Nelson, M.D., Detroit and P. J. Howard, M.D., Louisville, Kentucky are authors of an original article, "Breast Cancer During Pregnancy and Lactation," which was published in *Clinical Medicine* of April, 1956.

T. H. Joos, M.D., N. S. Talner, M.D., and J. L. Wilson, M.D., of Ann Arbor, are authors of an original article, "Risk of Surgery in Poliomyelitis Patients Dependent on Respirators," which appeared in *JAMA*, July 7, page 935.

A. C. Nolke, M.D., Detroit, is author of an original article, "Suppositories in Children," which appeared in *JAMA*, June 23, page 693.

A. R. Bauer, M.D., Detroit, is author of an article, "Mechanical Respirator for Newborn Infants and Other Patients," which appeared in *Clinical Notes, JAMA*, June 23, page 723.

\* \* \*

The Twenty-first Annual Congress of the International College of Surgeons, United States and Canadian sections, will be held at the Palmer House, Chicago, September 9-13, 1956. An elaborate program has been announced. There will be symposia on Trauma, Rehabilitation, Orthopedic, Neurologic and Occupational Surgery, Gall-bladder Surgery, Vascular Surgery, Gynecologic Surgery, Peptic Ulcer, Use of Segments of Bowel as Substitutes for Other Organs, and Carcinoma of the Breast. There are six sections with varying programs. Twenty renowned foreign specialists are expected.

\* \* \*

**New Polio Vaccine Regulations.**—On June 26, 1956, the Commissioner of Health announced new regulations for the use of Salk polio vaccine to take immediate effect, as follows:

**Rules and Administrative Policies Governing the Distribution and Use of Poliomyelitis Vaccine**  
Under Authority of Act 146, P.A. 1919, as Amended, Given Immediate Effect, Adopted and Filed with the Secretary of State on March 6, 1956

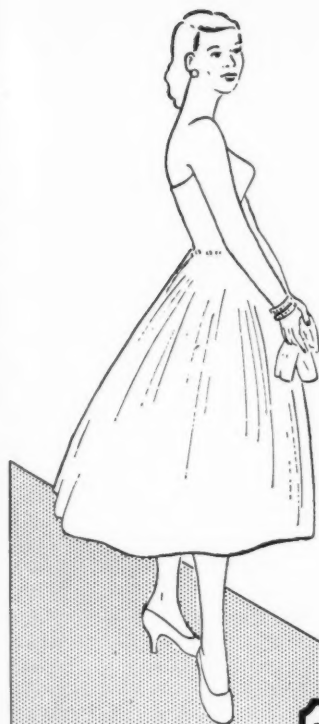
Rule No. 8 is hereby amended to read as follows:

8. Vaccine will be used only to give first and second and third doses to persons within the designated priority age groups. The second dose to be given not sooner than one month after the first, and the third dose to be given not sooner than six months after the second dose. The person's age at the time of the first injection shall be the deciding factor.

It was decided that 25 per cent of the future supplies of Salk Poliomyelitis vaccine would be distributed through commercial channels, but this does not change the requirement as to age priority—Commercial vaccine is limited by Michigan Law to children age 1 through 14 and pregnant women. It is also necessary to report

(Continued on Page 1010)

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(Continued from Page 1008)

the use of commercial vaccine in the same manner as vaccine received from the Health Department and given to your patients.

The children who are now eligible for a third dose of Salk vaccine would include the children who were vaccinated with two doses in the Spring of 1955, and those children and pregnant women who received their second shot in October, November, and December, 1955. As each week passes additional children will become eligible for their third dose.

\* \* \*

A recent study by the Michigan State Board of Registration in Medicine shows there are 155 students from Michigan in out-of-state medical schools. An effort is being made to induce most of them to return to their home state for practice. In contrast, the report shows that 200 Michigan students attend osteopathic schools, with about sixty returning to our state every year.

\* \* \*



More than 40 per cent of the tuberculosis patients discharged from Michigan's sanatoriums in 1955, left against medical advice. They numbered 1,713. Of these, 1,520 left with their disease uncontrolled.

A patient who leaves before his treatment is completed risks spreading his disease to his family and community. When the doctor can convince a tuberculous patient of his responsibility to himself and to society before the patient enters a sanatorium, something has been accomplished toward keeping him there until he is cured.

\* \* \*

The Ninth Annual University of Michigan Conference on Aging was held at the Michigan Union in Ann Arbor, July 9 to 11, 1956. Workshops were held to offer professional workers and community groups the opportunity to discuss methods for planning, developing, and integrating specific kinds of medical and social services. Also planned were demonstrations, seminars and clinics.

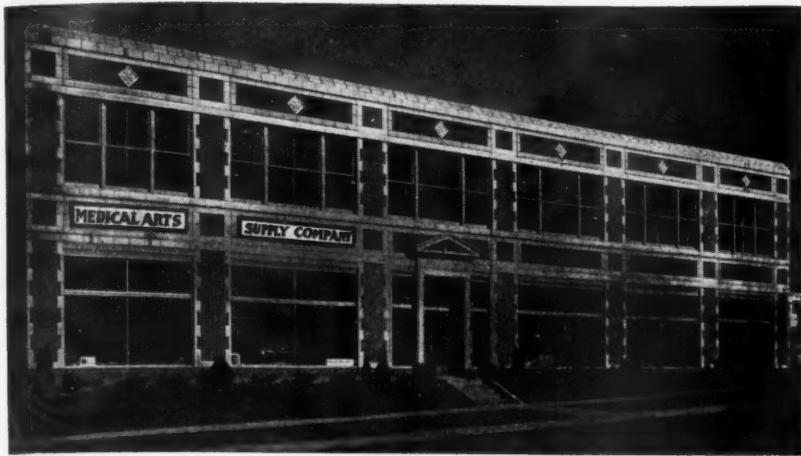
\* \* \*

**Distinguished Service Award.**—While attending a meeting of the American Academy of General Practice, of which he is President, John S. DeTar, M.D., of Milan, was among a group given Distinguished Service Awards by Dennison University, "in recognition of outstanding achievement and distinguished service which has contributed to an alert America." The recipients were Harold H. Burton, Associate Justice of the United States Supreme Court; Florence E. Allen, first woman to sit on a Federal Court of General Jurisdiction, also a member of the Supreme Court of Ohio; and John S. DeTar, M.D., President, American Academy of General Practice.

Dr. DeTar flew from Chicago, June 10, 1956, to appear Monday morning on the Arlene Frances TV

(Continued on Page 1012)

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(Continued from Page 1010)

program. He was back in Chicago in time to sit in the House of Delegates of the AMA.

\* \* \*

Nebraska Attorney General Beck has ruled that a county board has the right to purchase Blue Cross-Blue Shield group coverage for the needy persons of a county. He said it is evident that furnishing needy persons with such benefits is a governmental duty imposed on counties, and express authority is given counties to raise money by taxation for this purpose. Because there appeared to be no limitation of method for carrying out this duty, Beck said, the county board should be allowed to use its own discretion in performing it, provided a reasonable method is used. At one time, some years ago, the Michigan Social Welfare Department toyed with an arrangement to use MMS for this purpose. It fell through because of disapproval from Washington.

\* \* \*

The Commission on Professional and Hospital Activities, Inc., a new national service to improve hospital efficiency, has opened headquarters in Ann Arbor. Its Director is Dr. Vergil N. Slee, former Barry County health center director. Dr. Slee says service now extends to thirty-one hospitals in Michigan, Massachusetts, New York, Illinois, Ohio, West Virginia, Florida and South Dakota. Others will be added later. The Commission grew out of study conducted by Southwest Michigan Hospitals Council.

The Commission, at a charge of 25 cents per patient, provides a medical statistical service designed to help hospitals simplify medical records and analyze them more effectively. It also shows ways to improve medical and administrative practices.

Included among officers of governing body are president, Dr. Paul R. Hawley, director of American College of Surgeons, and treasurer, Dr. Edwin L. Crosby, AHA director. A Kellogg grant will support the program for three years, after which it will continue on a self-sustaining basis.—*Ann Arbor News*, June 23, 1956.

\* \* \*

The American College of Physicians held its Thirty-seventh Annual Session at Los Angeles, California, April 16-20, 1956, with a gross registration of over 4,500. Dr. Walter L. Palmer, of Chicago, was inducted as President. Other officers elected were: Dr. Richard A. Kern, Philadelphia, President-Elect; Dr. Chester M. Jones, Boston, First Vice President; Dr. George H. Anderson, Spokane, Second Vice President; Dr. Truman G. Schnabel Sr., Philadelphia, Third Vice President; Dr. Wallace M. Yater, Washington, D. C., Secretary-General. Dr. William D. Stroud, Philadelphia, was re-elected Treasurer.

The following men from Michigan were elected to membership:

Fellows—Muir Clapper, Detroit; Ivan Francis Duff, Ann Arbor; John Martin Miller, Ann Arbor.

Associate Members.—Robert William Corley, Jackson; Robert Dore Gittler, Ann Arbor; Floyd Banbury Leva-good, Detroit; Leland Dale Shaeffer, Jackson; John

(Continued on Page 1014)

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and nursing attention AND that, if they so desire, patients will be thoroughly indoctrinated with the program of Alcoholics Anonymous.

BRIGHTON HOSPITAL is NOT interested in the patient who merely wishes to be dried out in order to resume drinking. We ARE interested in those patients who really, fervently, seek complete rehabilitation and a way of life FREED from alcohol.

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## NEWS MEDICAL

(Continued from Page 1012)

Chandler Smith, Saginaw; Richmond Watson Smith, Jr., Detroit; Donald Henry White, Lincoln Park; Howard Raymond C. Eddy, Adrian; James Amos McLean, Ann Arbor.

The 1957 Annual Session will be held in Boston, Massachusetts, April 8-12; the 1958 Annual Session, in Atlantic City, N. J., April 28-May 2.

\* \* \*

Following the annual meeting and completion of the Part II Examinations of the American Board of Obstetrics and Gynecology, the following statistics were compiled:

Out of the total number of 471 new and reopened applications this year, 108 were postponed by the Credentials Committee. A total of 430 candidates took the Part I Examinations, and of forty-eight failures in this group, twenty-five were failures in the Written Examinations and twenty-three in Case Reports. There was a total of 415 candidates who participated in the Part II Examinations; 317 were certified and 99 failed.

Applications for certification for the 1957 Examinations are now being accepted. All candidates are urged to make such application at the earliest date possible. Deadline date for receipt of applications, new and reopened, is October 1.

Current Bulletins outlining present requirements may be obtained by writing to the Secretary's office: Robert L. Faulkner, M.D., American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.

The following Michigan physicians were certified by this Board May 20, 1956: Norman L. Banghart, Ann Arbor; Samuel J. Behrman, Ann Arbor; Charles J. Berger, Birmingham; Edmund L. Botch, Ann Arbor; Fred B. Gray, Grand Rapids; Arthur R. Rummel, Detroit; Perry E. Prather, Saginaw; James M. Riekse, Grand Rapids; John T. Rogers, Detroit; James H. Tisdell, Port Huron; Robert F. Trescott, Lansing; Clarence F. Webb, Grand Rapids; Joseph B. Woolfenden, Detroit.

\* \* \*

The Sixth International Congress on Laryngology will be held in Washington, D. C., May 5 through 10, 1957. The Scientific Program is complete and includes speakers from Sweden, Switzerland, Germany, England, Argentina, Canada, Italy, Yugoslavia, Japan, Brazil, Cuba, Netherlands, Austria, many of these countries sending several speakers. For details, write the General Secretary, 700 N. Michigan Ave., Chicago.

\* \* \*

Leonard A. Scheele, M.D., has resigned as Surgeon General of USPHS, effective August 1, to become president of Warner-Chilcott Laboratories. Last April he started his third term as Surgeon General. Requesting leave to resign, he wrote President Eisenhower he wished to provide more properly for his family. His twenty-three-year Public Health Service record was highly praised by the Chief Executive and Dr. Scheele's superior, Secretary Folsom.

(Continued on Page 1016)

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1. Pollock, B. E., and Pruitt, F. W.: *Am. J. M. Sc.*, 226:172, 1953.

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(Continued from Page 1014)

Several thousand 1956 medical graduates, who are liable for two years' military service, have started on hospital internships. Soon they will receive from Assistant Secretary of Defense (Health and Medical) a fact sheet on deferment for residency training. The intern who decides to participate will: (1) fill out and return by September 15, the form accompanying fact sheet; (2) submit his application for military commission by November 1, and (3), if he is selected for residency deferment, notify the Pentagon by February 1, 1957, that he has been accepted for training by an accredited hospital.

Some 900 young physicians have joined this "Berry Program"—500 first-year residents and approximately 400 others in advanced stages of specialty training. It is planned to select from the 1956-57 intern crop, 1,000 applicants for deferment beginning next year.

\* \* \*

For May, 1956, consumer price index for medical care (including physicians' and dental services, hospitalization and drugs) was 131.9. This compares with 131.6 in previous month, 105.4 in June, 1950, and 72.6 in 1939. Composite index for all consumer commodities and services was 115.4, with medical care standing at top of major categories, i.e., food, housing, transportation, etc. Of ten selected cities for which index figures were supplied by Bureau of Labor Statistics, Cleveland was highest in "medical care" bracket with 145.5; lowest, Scranton, Pennsylvania, 121.3. New York's index was 126.7; Detroit's, 142.4; Washington's, 123.4.

\* \* \*

The Ford Foundation has announced grants totaling \$6,826,850 to twenty-one research centers for strengthening and extending research in mental health.

The foundation said the grants were allocated from a 15-million-dollar appropriation announced in May, 1955. The money will be used in the next five years.

The Foundation also announced a grant of \$3,682,000 to the Foundations' Fund for Research in Psychiatry, New Haven, Connecticut, for development of research personnel and \$210,000 to the Mental Health Research Fund in London, for research and training in Britain.

Research projects include personality dynamics and development, biological, physiological and somatic problems, social and community aspects of mental health, children's disorders and studies in therapy.

Recipients include the University of Michigan psychology department, which will get \$313,000.—*Detroit Free Press*, June 25, 1956.

\* \* \*

The University of Michigan Triennial Medical Alumni Reunion will be held in Ann Arbor, September 27-28-29. For program and information, write A. C. Furstenberg, M.D., Dean, Medical School, University Hospital, 1313 E. Ann Street, Ann Arbor.

\* \* \*

Norman F. Miller, M.D., of Ann Arbor was named President of the American Gynecological Society at its annual meeting in Washington, D. C., May 23.

Congratulations, Dr. Miller!

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The Midwest Group of the Medical Library Association will hold its fall meeting at Henry Ford Hospital, Detroit, Michigan on October 19 and 20, 1956. The tentative program includes the following speakers: Dr. Jacques P. Gray (Parke Davis Co.) on "Medical Writing," Dr. James Barron (Henry Ford Hospital) on "Intravenous Feeding of Whole Food," and Dr. Lutfi M. Sa'di (Harper Hospital) on "Arabic Medicine." On Friday evening, there will be a dinner at Clinton Inn, Greenfield Village, after which the group will visit the Ford Museum. A library workshop is planned for Saturday morning.

\* \* \*

**Urology Award**—The American Urological Association offers an annual award of \$1000 (first prize of \$500, second prize \$300 and third prize \$200) for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been graduated not more than ten years, and to hospital interns and residents doing research work in Urology.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel William Penn, Pittsburgh, Pennsylvania, May 6-9, 1957.

For full particulars, write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1956.

T. P. Wickliffe, M.D., Calumet, was elected President of the Upper Peninsula Medical Society at its 1956 Annual Meeting in Sault Ste. Marie, June 22-23 which attracted a registration of 216.

Houghton was selected as the site for the 1957 convention, to be held in June, 1957.

\* \* \*

G. B. Saltonstall, M.D., Charlevoix, has been appointed official observer for the Michigan State Medical Society at the Tenth General Assembly of the World Medical Association, scheduled for Havana, Cuba, October 9-15, 1956.

\* \* \*

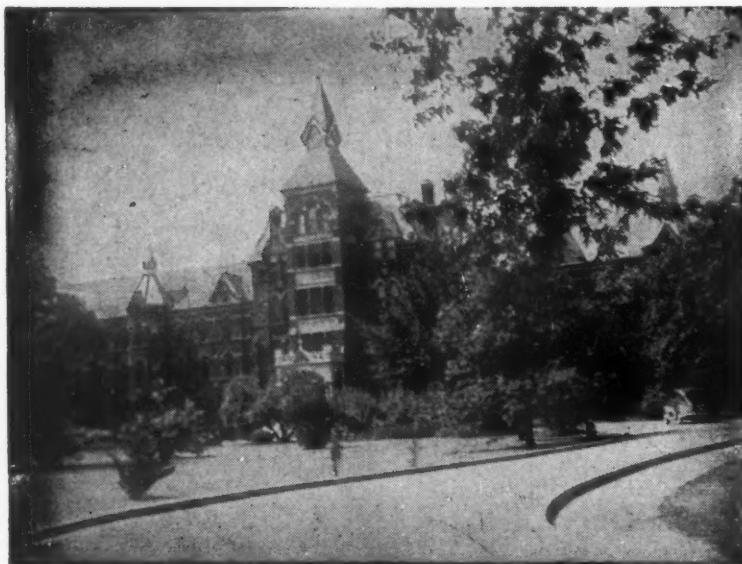
The 10th Biennial International Congress of the International College of Surgeons will be held in Mexico City, February 25-28, 1957. The official travel representative of the College, International Travel Service, 119 S. State Street, Chicago 3, has arranged an elaborate travel program to and in Mexico to add to the pleasure of those attending the Mexican Congress.

\* \* \*

The First International Cancer Cytology Congress will be held at the Drake Hotel, Chicago, October 9-11, 1956. This Congress is sponsored by the International Union Against Cancer, the College of American Pathologists, the American Society Clinical Pathologists, and the Inter-Cytology Council. The program will feature a series of broad discussions on the practical values of cytology diagnostic technique. For information and program, write Arthur H. Dearing, M.D., Prudential Plaza, Suite 2115, Chicago 1.

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**Medical Examiner Can't Call Coroner's Inquest.**—The Michigan Supreme Court, on June 28, ruled that when a county substitutes the medical examiner system for its coroner, it automatically does away with the coroner's inquest. The Supreme Court said the Legislature in enacting the 1953 medical examiner law intended to allow counties which so choose to "substitute pathological investigation in lieu of coroner-jury inquisition." The opinion held that the county medical examiner had neither the power nor duty to impanel a coroner's jury or to hold an inquest after voters have authorized a switch from the old system of investigating suspicious deaths.

\* \* \*

**The Sears-Roebuck Foundation**, in cooperation with the AMA made a grant of \$125,000 for the establishment of a Revolving Assistance Fund, to make loans to physicians desiring to establish or improve medical facilities in areas where the medical care is inadequate. The sole criteria, besides medical proficiency, has been the need of the community for medical service. In the short time the Fund has been in existence, 22 loans have been made affecting thirty-three physicians in thirteen states. Loans ranged from \$3,000 to \$25,000 and now total \$179,500.

The Foundation is now accepting applications for the last half of 1956. Those applications received before October 1 will be acted upon by December 15. The loans are on a ten-year non-secured basis, ranging from

0 to 6 per cent interest, depending upon the rapidity of repayment.

For information, write Norman H. Davis, Director, Medical Program, Sears-Roebuck Foundation, 3333 Arthington Street, Chicago.

\* \* \*

**Postgraduate courses on diseases of the chest**, sponsored by the American College of Chest Physicians, include a course at Hotel Knickerbocker, Chicago, October 15-19. For information and program, write the College at 112 E. Chestnut Street, Chicago 11.

\* \* \*

**Dr. Rueben L. Kahn**, discoverer of the famous Kahn reaction or Kahn test for the detection of syphilis, retired at the end of June after twenty-seven years of service to the University of Michigan as Professor of Serology in the Medical School and Director of Serologic Laboratories in the University Hospital.

Dr. Kahn, upon retiring, stated he is "retiring from routine only." He plans to concentrate his work on research.

Congratulations, Dr. Kahn, and may your important contributions be continued for many years to come!

\* \* \*

**The American College of Surgeons** will hold its 42nd Annual Clinical Congress in San Francisco, October 8-12, 1956. For the first time, student representatives from sixteen medical schools will attend the Clinical Congress at College expense. This is a new plan whereby a num-

ber of senior medical students will attend ACS Congresses every year—with schools participating in rotation, depending upon the geographic location of the meeting.

For program and full information, write the College at 40 E. Erie Street, Chicago 11.

\* \* \*

The AMA's June, 1956, meeting in Chicago drew a registration of 27,115 persons, including 9,969 physicians.

\* \* \*

Luther C. Carpenter, M.D., of Grand Rapids, and Vergil N. Slee, M.D., of Hastings, are members of the recently appointed Commission on Professional and Hospital Activities, Inc., which was created through the joint efforts of the American College of Surgeons, the American Hospital Association, the American College of Physicians, and the Southwestern Michigan Hospital Council. First act of the Commission will be to conduct a medical statistical service that will help hospitals simplify medical records and analyze records more effectively for improvement of medical and administrative practices. A Kellogg Foundation grant of \$260,000 will support the program for its first three years.

The Commission is an outgrowth of the Professional Activities Study carried on for the past three years by the Southwestern Michigan Hospital Council under the direction of Dr. Slee. The Michigan experiments demonstrated possibilities that the same methods could be of significant help to hospitals in all parts of the country.

\* \* \*

"Selected Problems of Current Significance" is the topic for the 29th Annual Graduate Fortnight October 15-26, 1956, sponsored by The New York Academy of Medicine. For program and full information, write the Academy at 2 E. 103 Street, New York 29.

\* \* \*

Of the two million diabetic persons in the United States, about one million don't know they have the ailment, according to the American Diabetes Association.

\* \* \*

Parke, Davis & Company has won *The Saturday Review's* award "for distinguished advertising in the public interest" during 1955. More than 400 advertising campaigns in magazines were screened—with Parke, Davis being one of the top five receiving the most votes from the awards committee. Singled out for special attention was the Detroit pharmaceutical firm's national advertisement headlined: "Is there one question you're too shy to ask your doctor?"

Congratulations, Parke, Davis!

\* \* \*

F. Maxwell Shuster, longtime district manager (including Michigan) for E. I. DuPont de Nemours Company, and the perennial "traffic director" at MSMS Annual Sessions and Michigan Clinical Institutes, just has been promoted by his corporation. Mr. Shuster is now in charge of the Florida Division, with permanent headquarters at Fort Lauderdale.

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Michigan doctors of medicine who attended the recent AMA annual meeting in Chicago were:

James R. Acocks, M.D., Marquette; U. M. Adams, M.D., Marcellus; Donald G. Alberts, M.D., Grand Rapids; W. H. Alexander, M.D., Iron Mountain; T. O. Anderson, M.D., Detroit; R. V. August, M.D., Muskegon; Carl E. Badgley, M.D., Ann Arbor; L. J. Bailey, M.D., Birmingham; A. S. Barefield, M.D., Detroit; G. Barone, M.D., Detroit; James Barron, M.D., Detroit; F. W. Baske, M.D., Flint; V. V. Bass, M.D., Saginaw; L. G. Bateman, M.D., Flint; G. H. Bauer, M.D., Ann Arbor; G. P. Beamer, M.D., Dearborn; J. H. Beaton, M.D., Grand Rapids; A. J. Beecher, M.D., Detroit; E. H. Beernink, M.D., Grand Haven; W. C. Behrens, M.D., Lansing; W. B. Bennett, M.D., Grand Rapids; T. I. Bergman, M.D., Highland Park; J. E. Berk, M.D., Detroit; Harry Berman, M.D., Flint; Leonard Birnbaum, M.D., Detroit; F. H. Bethell, M.D., Ann Arbor; G. C. Bishop, M.D., Almont; I. M. Blatt, M.D., Ann Arbor; M. A. Block, M.D., Detroit; W. D. Block, M.D., Ann Arbor; J. J. Boccia, M.D., Detroit; H. C. Bodmer, M.D., Kalamazoo; C. F. Boothby, M.D., Hartford; J. K. Bosch, M.D., Northville; H. E. Bowman, M.D., Grand Rapids; W. S. Briggs, M.D., Detroit; O. A. Brines, M.D., Detroit; W. R. Bristol, M.D., Detroit; H. S. Broderson, M.D., River Rouge; P. H. Broudo, M.D., Detroit; William Bromme, M.D., Detroit; E. M. Brown, M.D., Huntington Woods; F. W. Brown, M.D., Lansing; Jacob Bruggema, M.D., Ewart; R. C. Buerki, M.D., Grosse Pointe Farms; W. D. Buzzard, M.D., Chesaning; and Mary Lou Byrd, M.D., Grand Rapids.

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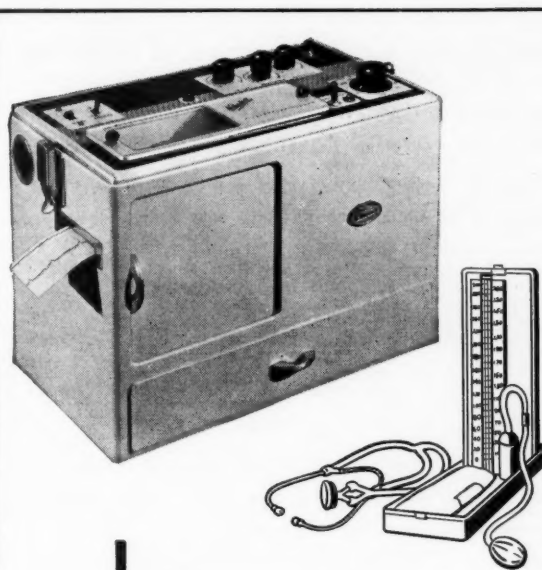
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Esophageal Surgery, one week, September 24.

Breast and Thyroid Surgery, one week, October 22.

Gallbladder Surgery, three days, October 29.

Fractures and Traumatic Surgery, two weeks, October 15.

**GYNECOLOGY AND****OBSTETRICS**—Obstetrics and Gynecology, three weeks, October 22.

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Internal Medicine, two weeks, September 24.

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Dermatology, two weeks, October 15.

Cardiology (Pediatrics), two weeks, November 5.

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\* \* \*

Applying color television to the teaching of medical science is the new task of Michigan medical men. Harry A. Towsley, M.D., Ann Arbor, Chairman of the University of Michigan Medical School TV Committee, stated recently, "The most important use we can make of this wonderful medium is as an adjunct to present teaching methods. Nothing will replace the vital teacher-student-subject relationship." The establishment of a color compatible television system in the University Hospital will be a U-M first. A grant of \$187,000 from the Dow Chemical Company inaugurated the program at the University of Michigan.

\* \* \*

The Ford Foundation recently announced a \$10,000,000 program of matching grants to the National Fund for Medical Education, to be made over a five-year period with a maximum limit in any one year of two million dollars.

Last year the National Fund—which distributes monies raised by the AMEF along with contributions from industry and the general public—received \$2,147,000 in unearmarked funds for distribution to the nation's medical schools. Of this amount, \$422,812 came from the medical profession through AMEF. Under the Ford Foundation formula, if these receipts are the same in 1956, a Ford grant totaling 70 per cent of this amount or \$1,503,486 would be made.

The National Fund for Medical Education is the organization which distributes to the medical schools the funds raised by the AMEF, along with the contributions made by industry and the general public.

Mr. Gaither said the Ford Foundation grants will be made on a matching basis over a five- to ten-year period with a maximum grant in any one year limited to \$2,000,000.

In 1955, the National Fund received \$2,147,000 in unearmarked funds for distribution to the nation's medical schools. Of this amount, an unearmarked \$422,812 came from the medical profession through the American Medical Education Foundation. Under the Ford Foundation formula, if 1956 receipts are equally large, there would be a Ford grant totalling 70 per cent of this amount, or \$1,503,486. All contributions in excess of the 1955 total would be matched dollar for dollar, subject to the annual maximum of \$2,000,000.

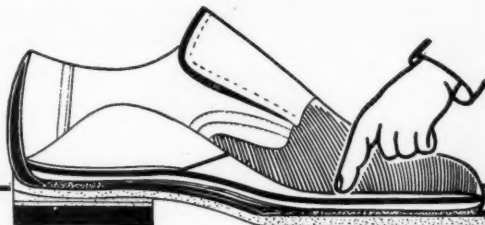
After 1956, each year's grant would match the preceding year's receipts on a diminishing scale, but all receipts over the preceding year's total would be matched dollar for dollar, up to the \$2,000,000 annual ceiling.

The announcement of these matching grants is very heartening to physicians who have contributed to the medical schools through AMEF. It will mean that for every unearmarked dollar contributed to AMEF, another 70 cents to a dollar will be given by the Ford Foundation, thereby stimulating additional financial support which the nation's medical schools have so critically needed.

JMSMS August, 1956

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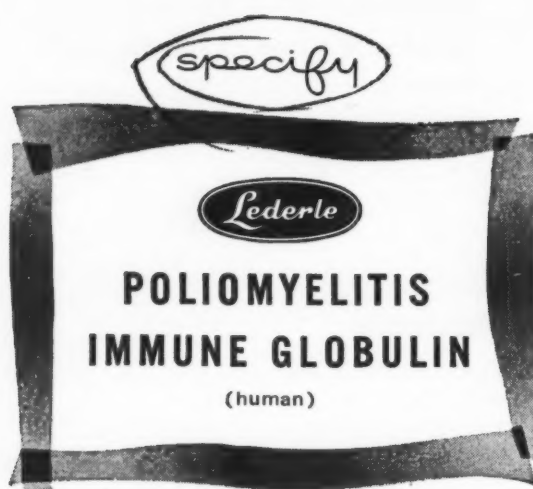
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\*Moyer, J. H., and others:

J. Chronic Dis. 2:670, 1955.

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### DOCTOR LOCATIONS—THROUGH JULY 1, 1956

| <i>Placed by<br/>Michigan Health Council:</i>   | <i>Open Practice In</i> | <i>Approximate<br/>Date</i> | <i>From</i>      |
|---|-------------------------|-----------------------------|------------------|
| C. L. Bahnik, M.D.                              | Owasippe Summer Camp    | June                        | Louisiana        |
| Neil Love, M.D.                                 | (Locum Tenens)          | June                        | Saginaw          |
| Winslow G. Fox, M.D.                            | Frankenmuth             | June                        | Charleston, Ill. |
| Edmund Talanda, M.D.                            | Ann Arbor               | July 1                      | Lansing          |
| Richard Heilman, M.D.                           | Stanwood                | July 1                      | Lansing          |
| <i>Assisted by<br/>Michigan Health Council:</i> |                         |                             |                  |
| Robert O. Ralston, M.D.                         | Pontiac                 | June 1                      | Ann Arbor        |
| Donald McCorvie, M.D.                           | Williamston             | June                        | Lansing          |
| Jesse Ketchum, M.D.                             | Royal Oak               | June                        | New York City    |
| William L. Hauptmann, M.D.                      | Royal Oak               | June                        | California       |

### MEDICAL TELEVISION SHOWS Produced by Michigan Health Council

| <i>Date</i>   | <i>Station</i>        | <i>Subject</i>                | <i>Guests</i>   |
|---------------|-----------------------|-------------------------------|---|
| June 3, 1956  | WJBK-TV, Detroit      | Alcoholism—The Revolving Door | A Film  |
| June 10, 1956 | WJBK-TV, Detroit      | Summer Care of the Skin       | Alice E. Palmer, M.D., Detroit<br>Coleman Mopper, M.D., Detroit |
| June 14, 1956 | WKAR-TV, East Lansing | Summer Health Habits          | Douglas Fryer, M.D., Lansing                                    |
| June 17, 1956 | WJBK-TV, Detroit      | Modern Heart Care             | A Film  |
| June 24, 1956 | WJBK-TV, Detroit      | Preface to a Life             | A Film  |

## THE DOCTOR'S LIBRARY

### THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

**PEPTIC ULCER.** Diagnosis and Treatment. By Clifford J. Barborka, M.N., M.S., D.Sc., F.A.C.P., Associate Professor of Medicine and Chief, Gastrointestinal Clinics, Northwestern University Medical School; Attending Physician, Passavant Memorial Hospital; Senior Consultant in Gastroenterology, Veterans Administration Research Hospital, Chicago, Illinois; formerly Consulting Physician, Mayo Clinic; and E. Clinton Texter, Jr., M.D., Associate in Medicine and Assistant Chief, Gastrointestinal Clinics, Northwestern University Medical School; Attending Physician, Passavant Memorial Hospital; Attending in Gastroenterology, Veterans Administration Research Hospital, Chicago, Illinois. 33 illustrations. Boston-Toronto: Little, Brown and Company, 1956. Price \$7.00.

**PULMONARY CARCINOMA.** Pathogenesis, Diagnosis, and Treatment. Edited by Edgar Mayer, M.D., and Herbert C. Maier, M.D. New York University Press, Washington Square, New York. Philadelphia and New York. J. B. Lippincott Company, 1956. Price \$15.00.

Eighteen physicians and surgeons have collaborated in the presentation of this excellent textbook covering all aspects of pulmonary carcinoma, stressing the early diagnosis of a cancer which has increased incredibly in the past twenty years with a death rate which has jumped 250 per cent in two decades. There are a great number of x-rays illustrating malignant and benign pulmonary lesions, well illustrated pathological specimens and slides, and an appendix with brief case histories which suggest pitfalls in diagnosis.

Surgical treatment, radiotherapy, radioisotope therapy and chemotherapy both curative and palliative are carefully presented, along with the medical management of the surgically incurable patient. Although there are detailed chapters on the functional aspects of pulmonary disease, the biology of cancer, its etiology, pathology, et cetera, which would mainly interest the specialist in this field, there is sufficient sound discussion of the diagnosis of lung cancer and its postoperative management to make this book of considerable value to the practitioner of medicine.

S.B.W.

**HYPNOTIC SUGGESTION.** Its Role in Psychoneurotic and Psychosomatic Disorders. A Thesis by S. J. Van Pelt, M.B., B.S., President of the British Society of Medical Hypnotists; Editor of the *British Journal of Medical Hypnotism*. New York: Philosophical Library, 1956. Price, \$2.75.

Hypnosis has again and again drawn the attention of physicians in the study and treatment of emotional disorders. Though the techniques have changed through the years and though the results of treatment by hypnosis have been variable, the enthusiasm of the hypnotist seems to have remained at a high level. The author of this monograph is no exception. The older methods are dismissed with a brief discussion, then the "author's original method" is introduced. The explanation of the theory and application of this approach is diagrammatic and amazingly simple. The illustrative case histories reveal unusually prompt and completely successful cures with a minimum of time and effort. Though interesting it seems unlikely that this monograph will provide much help for either the specialist or the general practitioner in the treatment of the neuroses.

F. O. M.

**ESSENTIALS OF DERMATOLOGY** By Norman Tobias, M.D., formerly Associate Professor of Dermatology, St. Louis University; Dermatologist, St. Louis State Hospital; Fellow, American Academy of Dermatology and Syphilology; Diplomate, American Board of Dermatology and Syphilology. Fifth edition. 211 figures. 11 subjects in color. Philadelphia and Montreal: J. B. Lippincott Company, 1956. Price, \$8.00.

The fifth edition of this book has been increased considerably in size, as compared with the previous edition. This is to allow for inclusion of a discussion of the newer drugs and techniques used in dermatology. It still includes only the essentials by describing adequately the common dermatoses and deleting the rare ones. Among other good features to aid the general physician is a chapter on the drugs causing eruptions, nursing instructions for hospital cases, instructions to patients and tables of localization of eruptions.

This is a handy book for quick reference, it is easy to read and is well illustrated. While this book does not contain the detail a dermatologist would want, it is an excellent volume to fit the needs of general practitioners and medical students.

H.E.A.

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As early as the 1880's, the organization recognized the value of trained disaster workers, the wisdom of using local committees to establish the disaster needs of their neighbors, and the importance of disaster rehabilitation. Through the years, the Red Cross has developed special techniques to cope with disaster problems, policies to administer relief, and procedures in preparedness that involve other agencies, institutions, and local, state, and national government agencies. Although these techniques and procedures are modified to meet changing conditions, the primary purpose of Red Cross Disaster Services remains the same: to alleviate human suffering.

When disaster strikes, the Red Cross is the warm heart of America in action, providing shelter, clothing, and food for the homeless, emergency medical and nursing care for the ill and injured, information for anxious families, and long-term aid to victims who cannot start again without help.

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